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January, 1962

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CHICAGO BO, ILLINOIS Research in the Service of Medicine

Abstract of AMA House of Delegates Action

Special Meeting, November 26-29, 1961



Social security health care, relations with the American College of Surgeons, organization of the AMERICAN MEDICAL POLITICAL ACTION COMMITTEE, medical discipline and polio vaccine were some of the major problems considered by the House of Delegates at the clinical meeting in Denver, November 26-30.

- ACS—The House agreed with the intent of five resolutions which expressed strong dissatisfaction over recent statements made by a spokesman for the American College of Surgeons. Approval was given to a report of the Board of Trustees informing the House that arrangements have been made for a January meeting with the ACS Board of Regents to discuss that organization's recent statements and policy positions. The report expressed hope that this meeting "will lead to a unification of effort in behalf of American medicine." The House instructed the Board of Trustees to take the five resolutions to the January meeting and to report to the delegates as soon as possible on the results of the meeting.
- AMPAC-The House heartily approved the purposes and goals of the recently organized AMERICAN MEDICAL POLITICAL ACTION COMMITTEE, and urged all physicians, their wives and friends to join AMPAC and other political action committees in their states and communities.

"Effective political action must be carried on at the local level and effective implementation must be done by local groups of physicians," the House said. "The formation of AMPAC recognizes the need for a national medical political action committee to coordinate the political activities of physican groups at all levels throughout the country."

POLIO-The House adopted a resolution which urged medical societies at the local, county, district or state level to encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis. The resolution stated that on the basis of the results of the surveys, the local medical society should determine the type of vaccine and the most effective type of program which would be of greatest benefit to the public.

Until such time as ALL THREE types of oral vaccine are available, the Salk vaccine should be the vaccine of choice for routine immunization, with the choice of program for administering the vaccine to be determined on a local level by each county medical society.

OTHER ACTIONS included:

Approving a statement that physicians have an ethical obligation to participate in medical society activities and express their opinions fully and freely.

Reaffirming AMA policy that it is not considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of the patient.

Agreeing with the Judicial Council that the physician himself is responsible for the control and custody of drug samples once they come into his posession, and in the "high tradition of the medical profession, he should not dispose of them in any way that could cause harm to others."

Commending those constituent medical societies which have made progress in the area of human relations by eliminating membership restrictions based on race or color.

Approving a recommendation that a special House committee be appointed to investigate all facets of the operation of the Joint Commission on Accreditation of hospitals.

Approving the combining of the AMEF and the American Medical Association Education and Research Foundation, effective January 1.

Reaffirming the previous policy that physicians should have the privilege of prescribing drugs by either generic or brand name.

Approving the principle of income tax deductions for medical care of the aged.

Endorsing the administration of indigent medical care programs developed in cooperation with local medical organiations as a legitimate activity of state and local health departments.

Urging every physician to use automobile seat belts.

Recommending a mass immunization program for the public as a civil defense measure.

Suggesting that the Board of Trustees continue negotiations to develop a group disability insurance program for AMA members.

Dr. Edwin S. Hamilton, as president of the Illinois State Medical Society, presented a check for \$185,000 to the American Medical Education Foundation at the first meeting of the House of Delegates on Monday, November 27. This brings the total donations from ISMS dues to \$1,576,620.00 since 1953.

▶ ISMS Introduced Three Resolutions:

- l. The resolution requesting benefits for women contract surgeons in World War I, was disapproved since the reference committee was informed by a member of the staff of the Legislative Department of the AMA headquarters that for the past three sessions of Congress, legislative measures concerning benefits for women contract surgeons have been considered by several committees of the Congress. This same question was considered several years ago by the AMA House, and at that time was also disapproved. The discussion on the floor of the House brought out the fact that if such action were taken by the Congress it would set a precedent and might well be the means of opening the door to similar action on behalf of other contract surgeons.
- 2. The resolution dealing with future physicians' clubs and Medical Explorer Posts, originating in Adams County, was referred to the Reference Committee on Medical Education and Hospitals. The Reference Committee recommended, and the House concurred in approval of the objectives of this resolution, and urged that state and county medical societies continue to expand their recruitment activities designed to interest qualified young people in medical careers. The Reference Committee further suggested that constituent and component societies consult with the Council on Medical Education and Hospitals regarding these important activities.
- 3. The third resolution, acted upon by the House without referral to a reference committee, was a tribute to the memory of Dr. Andy Hall. The House stood in silent tribute; a message of sympathy was transmitted to his family, and a copy of the resolution is to be published and sent to his family as soon as possible.

Illinois supported another resolution introduced by Dr. E. L. Compere of Chicago, delegate from the Section on Orthopedic Surgery. The resolution dealt with the importance of the work of the secretary of each scientific section of the AMA; asked that the Board of Trustees re-evaluate the matter of expenses of the section secretaries, and if possible, reimburse them for essential expenses incurred in connection with attendance at the annual meetings. The reference committee recommended, and the House approved, a substitute resolution which provided "that the Board of Trustees of the AMA re-evaluate the matter of expenses of the Section Secretaries for the purpose of equitable reimbursement."



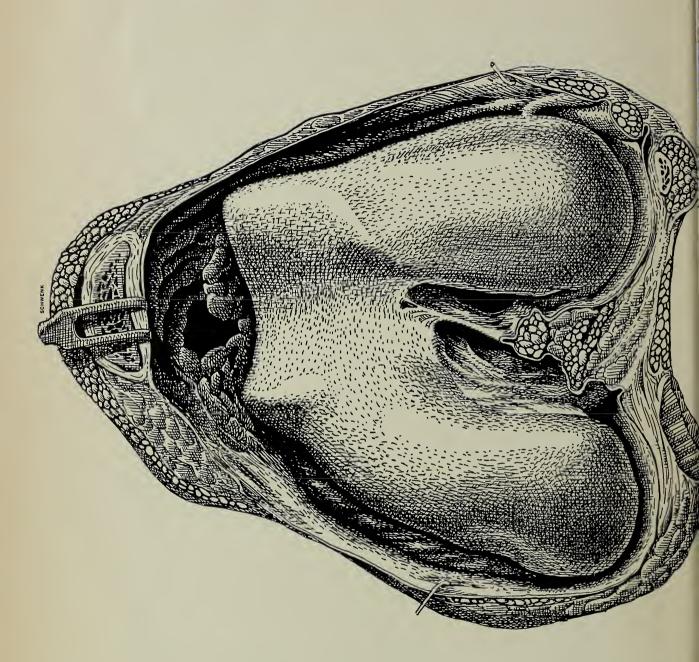
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because patients are more than arthritic joints...

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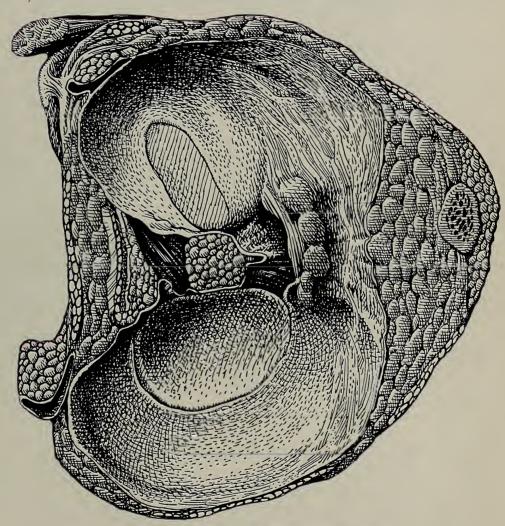
Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts — and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

4 Illinois Medical Journal

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for January, 1962



I SEE IT FROM '360'

By Robert L. Richards Executive Administrator

County Societies Organize for Better Services

THE CHICAGO MEDICAL SOCIETY has long been organized with staff and employees to better serve its 6,200 members, and the more than 3 million persons in Cook County. Other county societies such as Winnebago, Lake, Peoria, Tazewell, DuPage have also provided part-time and/or full-time executive services for their members. They, too, have established community activities to improve the public image of organized medicine. Some other county societies employ secretarial assistance in order to carry on official correspondence and routine duties. Most of the 92 component societies in Illinois do not have paid personnel.

Current information provided to me indicates that two county societies are planning to provide local executive services. They have investigated carefully the results of the other counties' experiences. They have heard Mr. David Meister, executive secretary of the Peoria-Tazewell County Medical societies explain his efforts in their behalf; a third county society will be added soon.

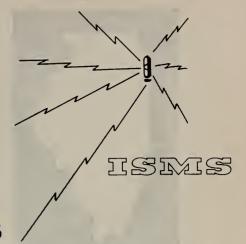
Two interesting experiments are about to be inaugurated. The Rock Island County Medical Society will possibly employ an executive secretary. This may become a joint operation with Scott County Medical Society, which is in the State of Iowa. There is every reason to believe that this can be successful.

The Will-Grundy County Medical Society is about to initiate a cooperative effort with the dental and pharmaccutical organizations. Together they expect to employ a full-time executive secretary, effective about March 1, 1962. In other parts of the country similar arrangements have been made. This joint effort should demonstrate, not only to the professions themselves but to citizens of the communities they serve, that the professions can work together to provide better services to the people of the area.

They plan to have an executive administrator organize the office and take over the usual duties of such an executive — organization, records and accounting, handle announcements and newsletters to the members, handle details for meetings, maintain liaison with the respective state and national organizations, maintain an office for relations with the public (information, grievances, speakers bureau, film distribution), and maintain press and radio relations.

The organization will be governed by a nine man board of representatives — three from each of the participating societies — which are now having their lawyers set up the official form for the association. Will-Grundy counties comprise an area of about 175,000 people, with the major communities of Joliet, Morris and Lockport within its boundaries.

The officers and staff of the State Society welcome the opportunity to work with new executive secretaries in a co-ordinated fashion to better provide for the members of the ISMS. Much can be accomplished in the future, and we expect to hear fine things about the Rock Island and Will-Grundy County society activities.



Announcements

Chicago Medical Society Conference

The 18th annual Clinical Conference of the Chicago Medical Society will be held February 27 through March 2 at the Palmer House in Chicago. Speakers represent educational institutions of national reputation.

A faculty of 33 outstanding physician-teachers will present scientific papers in daily sessions beginning at 8:30 a.m. In addition, there will be live telecasts from Michael Reese Hospital, medical films held daily, and special Instruction Courses, which require advance registration. Exhibits will be shown.

Attending physicians will meet the speakers at luncheon round table discussions and in panel groups.

February 27

James T. Grace, Jr., Buffalo, "The Virus Etiology of Cancer."

H. Marvin Pollard, Ann Arbor, Mich., "Polyps and Cancer of the Colon and Rectum."

Robert J. Lukes, Washington, D.C., "The Differential Diagnosis of Lymph Node Enlargement."

Warde Allan, Baltimore, "Exfoliative Cytology in the Diagnosis of Bronchopulmonary Cancer."

Walter P. Work, Ann Arbor, "Carcinoma of the Larynx and Adjacent Structure."

Eugene J. Van Scott, Bethesda, "Cancerous and Precancerous Lesions of the Skin."

Cornelius Verneulen, Chicago, "Cancer of the Prostate and Urinary Bladder."

Axel N. Arneson, St. Louis, "Female Genital Cancer." Franz Buschke, San Francisco, "The Value and Limitations of Radical Radiation Therapy of Cancer."

C. Gordon Zubred, Bethesda, moderator, panel on "Newer Chemotherapeutic and Hormonal Agents for

Cancer," with discussants: Anthony R. Curreri, Madison, Wis.; John D. Hurley, Milwaukee; George E. Moore, Buffalo.

February 28

Robert L. Jackson, Columbia, Mo., "The Management of the Young Diabetic."

M. Edward Davis, Chicago, "Indications for Caesarean Section."

Ernest Beutler, Duarte, Cal., "Iron Deficiency Anemias: Identification and Management."

Henry Swan, Denver, "Clinical Applications of Hypothermia."

Lt. Col. John A. Moncrief, Fort Sam Houston, "The Current Management of Burns."

Bernard B. Brodie, Bethesda, "The Mechanism of Action of a New Type of Antidepressant Drug."

Jesse E. Thompson, Dallas, "Recognition and Management of Carotid Artery Insufficiency."

Henry T. Ricketts, Chicago, "Selection of Patients for Treatment with Oral Hypoglycemic Agents."

Fredrick J. Stare, Boston, moderator, panel on "Atherosclerosis: Facts and Fancies," with discussants Wright R. Adams, Chicago; Jeremiah Stamler, Chicago; Joseph T. Doyle, Albany.

March 1

David Y. Hsia, Chicago, "Enzyme Defects in Children."

Joseph T. Doyle, Albany, "The Natural History of Hypertension."

Louis Weinstein, Boston, "The Abuses of Antibiotics."
H. William Clatworthy, Jr., Columbus, Ohio, "The Surgically Sick Child."

Joseph D. Boggs, Chicago, "Clinical and Laboratory Studies with Hepatitis Virus."

H. William Scott, Jr., Nashville, "Recent Advances in Surgery."

James D. Hardy, Jackson, Miss., "Principles in Pre- and Postoperative Care; Pulmonary-Arterial-Alimentary."

Roy T. Parker, Durham, N.C., "The Management of Breech Presentation."

Clinicopathologic Conference: "Obstetrics and Gynecology," Arthur T. Hertig, Boston, moderator, with John I. Brewer, Chicago; Ronald R. Greene, Chicago; John F. Sheehan, Chicago.

March 2

Kenneth M. Brinkhous, Chapel Hill, N.C., "The Hemorrhagic Diseases."

Henry W. Brosin, Pittsburgh, "The Management of the Neurotic and Emotionally Disturbed Patient."

Edward W. Lowman, New York, "Self-Help Devices for the Physically Handicapped."

Felix Wroblewski, New York, "The Diagnostic Value of Serum Enzymes in Clinical Medicine."

Registration fee is \$10. An additional charge of \$10 will be made for each of the instructional courses. For information write the Society at 86 E. Randolph St., Chicago 1.

A Symposium on The Challenge of Advancing Years

The American Geriatrics Society will present this symposium February 10 at the Sheraton-Chicago Hotel as its interim meeting. Cooperating societies are the Illinois State Medical Society and the Chicago Medical Society. A question and answer period will follow each half day session.

Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois College of Medicine, will moderate the morning session. The physician-speakers are:

Edward L. Bortz, Philadelphia, "New Horizons for Advancing Years."

Frederick J. Stare, Boston, "Proper Eating Has Become a Science."

Jeanne C. Bateman, Washington, D.C., "How Far Around the Corner is Cancer Control?"

Walter A. Fansler, Minneapolis, "Special Problems in Proctoscopic Examination of the Geriatric Patient."

Dr. Edward Henderson, editor-in-chief of the Journal of the AGS, will be the moderator of the afternoon session, with the following participating physicians:

Jack Weinberg, Chicago, "How Are Folks Facing the Future?"

Carroll B. Larson, Iowa City, "Bones and Joints Which Are Wearing Out."

Frank H. Krusen, Rochester, Minn., "Why Accept Strokes as an Irreparable Calamity?"

David I. Abramson, Chicago, "An Approach to Better Circulation in Extremities."

Dr. A. Clayton McCarty, president of the

AGS, will preside at the luncheon at 12:45. Tennyson Guyer, Ph.D., public relations specialist, Findlay, Ohio, will be the speaker.

The meeting was made possible by a grant from Lederle Laboratories.

Congress on Maternal and Infant Health

"Science, Service, and Sentiment in Modern Maternal and Infant Health" will be the theme of the Illinois Congress on Maternal and Infant Health to be held at the St. Nicholas Hotel, Springfield, February 7-9. The congress will offer 30 breakfast conferences, eight luncheon conferences, 45 round tables, and two formal papers designed for maximum participation in group discussion of medical, legal, nursing and sociological problems.

Dr. Joseph R. Christian, River Forest, is general chairman, and Dr. Edward M. Dorr, Chicago, heads the program committee. Dr. Noel G. Shaw, Evanston, is president.

All physicians are invited to participate in the association's essay contest and may write for details to the headquarters at 116 S. Michigan Ave., Chicago 3.

Society for Surgery of the Hand to Meet

Friday and Saturday, January 26 and 27, are the dates set for the annual meeting of the American Society for Surgery of the Hand at the Palmer House, Chicago. Thirty papers are scheduled by physicians from throughout the country and Italy, Argentina, Ontario, Montreal, and Vancouver, B.C.

Ophthalmologist's Clinical Conference

The Chicago Ophthalmological Society's annual Clinical Conference will be held February 16 and 17 at the Drake Hotel in Chicago.

According to the preliminary program, guest speakers will include Drs. David G. Cogan, Boston; Arthur G. DeVoe, New York; John R. Fair, Augusta, Ga.; Trygve Gundersen, Boston; John S. McGavic, Bryn Mawr, Pa.; C. Wilbur Rucker, Rochester, Minn.; Daniel Ruge, Chicago, and Mr. R. Ross Russell, Oxford, England.

The Gifford Memorial Lecture will be delivered by Dr. Cogan on Friday, February 16, at 5:15 p.m. All physicians are invited to attend the lecture and dinner which follows.

Registration fee for the entire course including round table luncheons and dinner is \$45, payable to the Registrar: Mrs. Mary E. Ryan, 1150 N. Lorel Ave., Chicago 51.

Orthopaedic Surgeons' Annual Meeting

The American Academy of Orthopaedic Surgeons will have its annual meeting January 27 through February 1 at Chicago's Palmer House. Instructional Courses are scheduled from January 28-30; faculty for the course will number 182. The Course dinner will be January 29 in the Grand Ballroom, with Dr. H. Relton McCarroll as moderator of the program's panel discussion.

The scientific program will run from January 27 through February 1, with the first half day's session a combined one with the Orthopaedic Research Society. The president's guest speaker on January 31 will be Dr. W. Alexander Law, London, England, who will speak on "Experience with Long Term Results in Mould Orthroplasty of the Hip."

The Audio-Visual Program will run in the afternoons, January 27-31. Opening speaker Dr. Jörg Böhler, Linz, Austria, will talk on "Neurovascular Pedicles."

Change in Rockford Blue Shield

The Hospital Service Corporation (Illinois Blue Cross headquartered in Chicago) officially became agent for the Medical-Surgical Service of Illinois (Rockford Blue Shield) on November 1, at the request of the Rockford Blue Shield Board. It will provide the necessary services: sales, accounting and claim handling.

The plan had previously operated under an agency agreement with Illinois Hospital Service (Rockford Blue Cross). Last July the Rockford Blue Shield Board of Trustees was notified by the Illinois Hospital Service that the agreement and all services were to be terminated as of Nov. 1, 1961. Reasons for the termination of the previous Rockford agreement were not revealed.

The Rockford Hospitalization organization, although holding the name of Blue Cross, has for some time been an independent corporation unaffiliated with either the national Blue Cross Association or the American Hospital Association. The Rockford Blue Shield Plan, however, has retained its medical society sponsorship as well as its membership in the National Association of Blue Shield Plans. As as result of the new agency agreement with the Hospital Service Corporation headquartered in Chicago, the Rockford Blue Shield Plan has now established a business relationship with a nationally affiliated and AHA-approved Blue Cross Plan.

Medical-surgical protection will continue with no change in rates or benefits for members of the Medical-Surgical Service, and the plan will retain its individual identity with policy determined by its own Board of Trustees.

In recent years, the corporation has been the only AHA-approved, nationally associated Blue Cross Plan in the state. Today, the Rockford and Chicago Blue Shield plans are the only Blue Shield plans approved by the National Association of Blue Shield Plans to provide medical-surgical coverage to Illinois residents.

A New Group Medical Expense Insurance Plan*

A new group Medical Expense insurance plan has been adopted by several of the leading automobile companies covering their Illinois employees.† This new plan, effective Jan. 1, 1962, covers a substantial number of employees and their dependents.

The plan bases benefits on the reasonable and customary charges of the physician rendering the service, rather than on a specific fee schedule of allowances. Also, in most cases benefits under the plan are payable directly by the insurance companies to the physician rendering those services that are covered.

Benefits for two classes of medical services are as follows: Type I services are surgery, obstetrics other than prenatal and postnatal care, physicians' visits in a hospital for non-surgical care, anesthesia services, emergency (continued on page 24)

Chrysler Corporation — Aetna Life Insurance Co.

^{*}Submitted for publication by the Health Insurance Council

[†]The automobile companies and insurance carriers involved in this program:

General Motors — Metropolitan Life Insurance Co. Ford Motor Company — John Hancock



Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most

patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Thorazine® brand of chlorpromazine a fundamental drug in both office and hospital practice
Smith Kline & French Laboratories

'THORAZINE' PRESCRIBING INFORMATION

**THORAZINE' PRESCRIBING INFORMATION
Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine** Reference Manual and *Physicians* Desk Reference, and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE
Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE
Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—Starting aral dasage is 10 mg, t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg, to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. Starting intramuscular dase is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d. Alcoholism—Severely agitated patients: Starting intramuscular dose is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. Agitated but manageable patients: Starting aral dase is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, starting aral dasege is 10 mg, t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

is administered.

CHILDREN'S DOSAGE
For Behavior Disorders—Oral dasage is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). Rectal dasage is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). Intramuscular dasage is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given slowly, deep into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery. 'Thorazine' Injection should not be mixed with other agents in the ministration is recommended only for severe niccups and surgery.
'Thorazine' Injection should not be mixed with other agents in the
syringe. Because contact dermatitishas been reported with 'Thorazine',
nurses or others giving frequent injections should avoid getting the
solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight
yellowish discoloration will not alter potency or efficacy. If markedly
discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine. the dosage or by administering small amounts or dextro ampinetamine. Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses,

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Auntice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease. If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory

laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted. Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

be observed particularly during that period. A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms. Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ½ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.) necessary.)

if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vaso-constrictor is required, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see Physicians' Desk Reference). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50,500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc.

as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glycery I monopalmitate, glycery I monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

 $\bigstar\text{`Levophed'}$ and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.

Announcements (continued from page 21)

first aid. Type II services are radiological diagnostic and radiological therapeutic services; diagnostic and consultation services; and technical surgical assistance. A more complete description of Type I and Type II services is contained in the booklet to be made available at an early date.

For Type I services the plan undertakes to pay the full reasonable and customary physicians' charges for persons earning up to \$7,500 a year. This includes practically all hourly-rate employees and a substantial proportion of salaried employees. In cases where the employee's annual earnings are in excess of \$7,500, the plan will pay whatever would be the reasonable and customary charge applicable to a person earning between \$5,000 and \$7,500 a year.

With regard to Type II services, the insured employee will pay the first \$5 or 10 per cent of the fee, whichever is greater, for the particular service rendered and the plan will pay the remainder. There is a yearly limit on the payments for which the employees are responsible. It ranges from \$25 to \$75 per person, depending on his earnings-class.

The plan relies on the reasonableness and good judgment of the medical profession in setting charges. The insurers feel the plan will succeed if charges are reasonable and are kept at their customary levels by each physician. If physicians raise their charges above these levels, the cost of the plan will be increased unnecessarily to the dissatisfaction of those who will bear the increases. Insurance companies have for a number of years offered plans which do not rely on schedules of allowances with generally satisfactory results.

Two AMA Foundations Combined

Effective January 1, the programs of The American Medical Education Foundation and the American Medical Research Foundation were consolidated within the framework of a single foundation — the American Medical Association Education and Research Foundation. The original programs will also be expanded and a concerted effort made to provide increased financial assistance to medical schools, in addition to financing other projects of the

foundation, such as medical scholarships.

PG Courses

A postgraduate course in Gynecologic Endocrinology will be given at Michael Reese Hospital by the department for research in human reproduction and selected faculty. The class will meet from 9 a.m. to 5:15 p.m. February 5, 6, and 7. It is acceptable for 32 hours of Category II credit by the American Academy of General Practice.

The lecture schedule may be obtained from Miss Barbara Moore, department for research in human reproduction at the hospital, 2900 S. Ellis Ave., Chicago 16.

Clinics for Crippled Children

- Feb. 2 Chicago Heights (Cardiac), St. James Hospital
- Feb. 7 Alton (Rheumatic Fever), Alton Memorial Hospital
- Feb. 7 Hinsdale, Hinsdale Sanitarium
- Feb. 7 Metropolis Methodist Educational Building
- Feb. 7 Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Avenue
- Feb. 8 Anna, County District Hospital
- Feb. 8 Springfield (General), St. John's Hospital
- Feb. 9 Evanston, St. Francis Hospital
- Feb. 13 East St. Louis, St. Mary's Hospital
- Feb. 13 Peoria (General), Children's Hospital
- Feb. 14 Champaign-Urbana, McKinley Hospital
- Feb. 15 Elmhurst (Cardiac), Memorial Hospital of DuPage County
- Feb. 15 Macomb, McDonough District Office
- Feb. 15 Rockford, St. Anthony's Hospital
- Feb. 20 Belleville, St. Elizabeth's Hospital
- Feb. 21 Chicago Heights (General), St. James Hospital
- Feb. 22 Bloomington (General), (A.M.), St. Joseph's Hospital
- Feb. 22 Litchfield, Madison Park School
- Feb. 27 Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital
- Feb. 27 Peoria (General), Children's Hospital
- Feb. 28 Aurora, Copley Memorial Hospital
- Feb. 28 Springfield (Cerebral Palsy), Memorial Hospital

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Surgical Removal of the Dislocated Lens

EARL H. MERZ, M.D., BURTON ZEIGER, M.D., IRVING PUNTENNEY, M.D., Chicago

IN A RECENT REVIEW of the subject, removal of dislocated lens, Calhoun and Hagler¹ stated: "There is no general agreement among authorities in the current literature or in the standard textbooks concerning the indications for the surgical removal of the dislocated lens, and there is much confusion and disagreement as to which of the many techniques available is the most desirable, once surgical treatment has been decided upon."

It is the purpose of this discussion to add more cases to the series presented by Calhoun and Hagler, and to show a modification of their needle, which we believe makes the surgery easier, more exact, and less traumatic.

The technique is essentially the same as that originally described by José Barraquer² and modified by Calhoun. A double-pronged needle is passed through the pars plana area behind the lens; this traps the lens, supports and holds it anteriorly, and prevents it from dropping into the posterior chamber. We have

nothing to add to the controversy concerning the indications for removal of the dislocated lens but wish to show our modification of the technique and present our results. The more cases reported with satisfactory results, the more readily will the ophthalmologists attempt this surgical procedure.

Our recent series consists of the four cases, two with completely luxated lens and two with subluxated lens. In all cases the following technique was used.

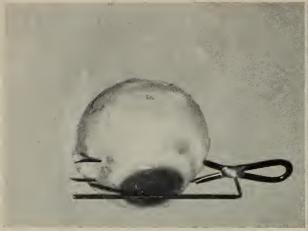
Technique

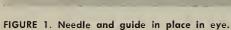
Preoperative preparation was the same as for routine cataract extraction, and patient cooperation was good. The pupils were dilated with neosynephrine and homatropine. Akinesia, anesthesia, superior rectus suture, lateral canthotomy, limbus-based conjunctival flap, and placement of three McLean corneoscleral sutures of #6-0 black silk were used as for a routine cataract extraction.

The patient was placed in a supine position on the operating table. The head was draped and firmly fixed with towel clips, as was the eye drape, so that they could not be displaced when the patient was moved.

After the limbus-based flap was dissected,

From the department of ophthalmology, Veteran's Research Hospital, Chicago





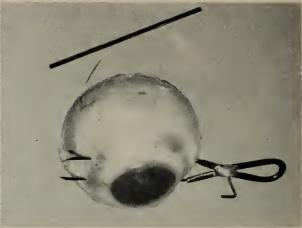


FIGURE 2. Needle in eye with guide removed.

partially-penetrating groove incisions were made at the 10, 12, and 2 o'clock meridians. A scratch incision was made in the sclera in the horizontal meridian temporally, parallel to and 6 mm. from the limbus. This marked the site of the scleral penetration and also made easier the introduction of the double-pronged needles.

The patient was then turned to a prone position on an adjacent operating table, with the chin and face extending beyond the table edge and the face directed downward. The operator and assistant were seated on low stools beneath the patient's head. (Arm rests were constructed of sterile towels to support the surgeon's arms while operating in this unique position.) The dislocated lens fell forward into the pupillary opening. The modified Calhoun needle with its "guide prong" was now ready for use. Maintaining good scleral fixation, the double-pronged, sharp-cutting points of the needle were introduced into the previously made scleral incision along a plane parallel to the iris. To insure proper passage of the double-pronged needle across the eye, the third or guide prong lies anterior to the cornea and acts as a guide. This insures that the double-prong needle penetration is not too deep nor too shallow. The points of the needle exit through the sclera at the same distance from the limbus, 6 mm., as was the entrance of the needle (Fig. 1).

In the first case, without the guide-prong, the needle exited 4 mm. from the limbus but still trapped the lens. In the second case, the exit was 9 mm. from the limbus, which was too far posteriorly; the needle was retracted and re-

placed. When the guide is not used and one is not sure where the needles will emerge, the placement of the double-pronged needle is slower. With the guide-prong over the cornea to help in the placement of the needle, which we want parallel to the iris, the needle enters and exits quickly at the sites desired, avoiding trauma to the retina and ciliary body. Penetrating the retina with the needle point could cause a retinal hole or tear and secondary separation of the retina.

After the needle is in place and the lens supported from behind by the needle prongs, the guide-prong is then easily removed and in no way interferes with the operation (Fig. 2). The patient was rolled back to the original supine position. Three sutures were preplaced in the cornea and sclera. An incision was made into the anterior chamber at the limbus with a keratome, and enlarged with corneoscleral scissors. The needles provided support so that a Lewis lens scoop could be passed behind the lens. Mild counter-pressure with muscle hook expressed the lens. An erisophake or capsule forceps could have been used for this purpose. A complete iridectomy was performed in all cases.

The preplaced sutures were tied and routine postoperative cataract care followed. In all cases a large air bubble was inserted into the anterior chamber. The needle was removed, as suggested by Calhoun, by fixating "the sclera near the exit site," a lens loop was held about the entrance sites for counter-pressure, and the needle pulled from the eye.

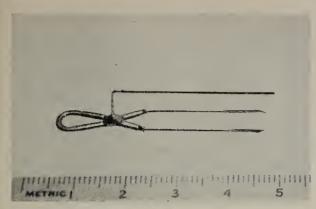


FIGURE 3. Photo illustrating size.

Case Reports

Case 1. T.E.M., a 61 year old white man, had progressive loss of vision in both eyes. There was no history of injury to either eye. His general health was excellent and no cause for cataracts was known.

Physical examination revealed a well developed, well nourished white male who was not acutely ill or in distress. Visual acuity without correction was 8/200 in the right eye; with a pinhole it was 20/70. The aphakic left eye showed a visual acuity of 20/100 with a +10.00sphere and a pinhole. The tension in the right eye was 34.5 mm./Hg (Schiotz) and in the left eye 24 mm./Hg (Schiotz). The external examination of the right eye was normal except for a grayish lenticular opacity in the pupillary area. The left eve revealed a widely dilated pupil with a mature cataractous lens that moved into and out of the pupillary area with movement of the eveball. A moderately severe iris atrophy was noted, and there was no reaction of the pupil to either light or to miotics. Fundus examination of the right eye was not possible because of the lenticular opacity. The fundus of the left eye appeared to be normal for a patient of this age. No hemorrhages, exudates, nor choroiditis was noted.

Laboratory tests were normal.

The diagnosis was (1) cataract, mature, luxated, left eye, associated with iris atrophy; (2) glaucoma, chronic, open angle, secondary to the dislocated lens; (3) cataract, mature, senile, right eye.

Treatment was discussed in the text.

Case 2. F.R. was transferred to the eye serv-

ice from the peripheral vascular service at the Veteran's Research Hospital because of poor vision in the right eye. He noted an initial loss of vision in 1945, and in 1947 he said the vision "was gone." In January, 1960, he developed pain in the right eye, associated with severe headaches. The eye became red and inflamed. He entered the hospital requesting treatment.

The general physical examination was noncontributory. The vision in the right eye was light perception with questionable projection. The vision in the left eye was 20/30, improved to 20/25 with a pinhole. Red-green discrimination was excellent in the left eye but questionable in the right eye. External examination of the right eye showed a dilated pupil, deep anterior chamber, hazy cornea, and a poor pupillary reaction to light and accommodation. There was a mild scleral injection and flush. External examination of the left eye showed it was normal. The intraocular tension of the right eye was 59 mm./Hg (Schiotz) and the left eye 17 mm./Hg (Schiotz). In the pupillary area of the right eye was a definite opacity due to a mature cataract. The iris was tremulous and definitely atrophic. No flare cells or keratitic precipitates were seen in either eye. Fundus examination was not possible because of the mature cataract. The lens, media, and fundus of the left eye were normal.

The patient was started on miotics and acetazolamide, and the tension was brought under control.

The diagnosis was (1) cataract, mature, subluxated, right eye; (2) glaucoma, open angle, secondary to subluxated lens of right eye.

The treatment was the same as discussed above.

Case 3. C.C., a 35 year old Negro, was admitted to the Veteran's Research Hospital on Jan. 12, 1961, complaining chiefly of decreased vision in the right eye. He had been struck in that eye during a robbery in September, 1960. Since then the vision had become progressively worse. There was no pain and the eye was not red or inflamed.

Physical examination was not contributory. Eye examination showed vision in the right eye to be light perception only; in the left eye 20/25. The external examination was normal except for a slight haziness of the right cornea.

The tension in the right eye was 36 mm./Hg (Schiotz) and in the left eye 20 mm./Hg (Schiotz). The right pupil was 4 mm., fixed, and did not react to light. The left pupil was normal. The right anterior chamber was shallow and the right lens was subluxated. The anterior chamber of the left eye was of normal depth. The fundus of the right eye could not be seen because of the cataract. The left fundus was normal throughout.

Laboratory tests were normal, including x-ray for foreign bodies.

Diagnosis was cataract of right eye, subluxated, with secondary glaucoma, due to traumatic injury to right eye.

The treatment was cataract extraction with Calhoun needle.

Case 4. K.J.V., a 36 year old man, was hit in right eye by a wrench one year previously. Hyphema cleared revealing a dislocated lens. The patient had occasional pain, tearing, and redness in the right eye.

Physical examination revealed a well-developed, fairly obese white male. Visual acuity was correctable to 20/20-3 in both eyes. Tension in the right eye was 30+ mm./Hg (Schiotz) and in the left eye 18.5 mm./Hg (Schiotz). On examination a dislocated lens was noted to fall forward touching the cornea when the patient was in a prone position. The rest of the physical examination showed no serious pathology.

Operation as described previously was performed. The postoperative course was not remarkable. At a recent examination the right eye was white and quiet, the media was clear, and the fundus was intact. Visual acuity was 20/100 with pinhole.

The results of surgery in the four cases of dislocated lens were very satisfactory. The patients made uneventful recoveries, without vitreous hemorrhage, retinal separation, or uveitis. A vitreous loss occurred in two patients at the moment of the meridian incision. The vitreous was removed by excision with a scissors and a spatula.

In all four patients the tension was normal following surgery, and without the use of miotics or acetazolamide.

Follow-up on the four cases showed vision ranging from 20/50 to 20/70 with correcting

Conclusions

We feel that the "double-prong needle method" for removal of a dislocated lens is a good procedure and perhaps the best way of delivering a dislocated lens.

Modifying the needle to include the detachable guide-prong has a distinct advantage in making insertion quicker, smoother, surer and more accurate, with less danger of damage to the ciliary body or the retina. There is no disadvantage in the use of the guide since it is removed after the needle is correctly placed through the eye, and does not interfere with removal of the cataract or conclusion of the operation.

We wish to add our four cases to the 20 reported by Calhoun and Hagler.

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The Cost of Science Education

If present trends in college and graduate school registration continue, the U. S. can double the number of students receiving doctoral degrees in science and engineering and the number of professional scientists and engineers in its labor force

by 1970. To do so, however, it will have to increase expenditures for science and engineering education in colleges and universities from the 1961 level of \$2.1 billion a year to \$5.5 billion a year in 1970. In addition, the institutions will need \$2.7 billion instead of the present \$900 million a year to carry on the basic research that is an essential part of university science education. Scientific American, September 1961.

Dermatologic Manifestations of Internal Diseases

MARCUS R. CARO, M.D., Chicago

WITH THE EXCEPTION of contact dermatitis, superficial parasitic infestations, some superficial pyogenic and fungal infections, and some tumors that may be strictly local in the skin, all dermatoses may at times be cutaneous counterparts of lesions of internal organs; or they may be consecutive upon skin changes produced by systemic disease.

Itching

Toxic substances of many systemic diseases cause itching. This is true in a diabetic patient, even when visible lesions are not present. In addition, a superimposed candidiasis may aggravate itching, and bacterial infections are common. In liver or biliary disease, itching often precedes visible jaundice and may resist treatment. In renal disease retained metabolites entering the skin generally produce severe itching, usually unrelieved until the terminal stage of uremia. Itching is often present in gout. Occasionally internal cancer is accompanied by intractable itching even in the absence of metastatic lesions in the skin. Generalized itching may also be caused by intestinal parasites, and in the lymphoma-leukemia group severe generalized itching may occur before any primary cutaneous lesions. Itching may accompany

Chairman's Address presented to the Section on Dermatology, Illinois State Medical Society annual meeting, May 16, 1961, Chicago anemia and blood dyscrasias, such as polycythemia vera, and also cerebral arteriosclerosis.

Pigmentation

Pigmentation of the skin or mucous membranes may represent the local deposition of metals such as silver, bismuth, or gold, and these may often be identified by a dark-field examination of a section. In hemochromatosis some of the pigment is hemosiderin which can be stained by Perls' Prussian blue reaction. Deposition of melanin in the skin and mucous membranes is seen in Addison's disease and following encephalitis, and darkly pigmented macules are seen on the lips and in the mouth of patients with hereditary multiple polyposis involving the intestine.

Signs of Malignancies or Tumors

In acanthosis nigricans there is pigmentation on the flexures, axillae, neck, and often under the breasts, and a papillomatosis on the affected sites that gives them a velvety feel. In the adult form of this disease an underlying malignant tumor of some internal organ is often present.

A visceral malignancy may occasionally manifest itself by a perisitent erythema multiforme. In a recent case, such lesions had been present for several months when laparotomy revealed a carcinoma of the colon with extensive metastases. Paget's disease of the nipple may be mistaken for eczema which, lacking quick re-

sponse to topical ointments, should be examined histopathologically. Recently, far-advanced carcinoma of the breast was found in two patients whose diseased nipples were being treated with ointments. The association of Bowen's disease with primary carcinoma of some internal organ is statistically significant.

Carcinoma of the breast may also produce metastases to the scalp seen as discrete, hard, adherent papules devoid of hair. The scalp is a favored site for metastases from malignant tumors of many organs, but the lesions may also appear anywhere on the skin. A biopsy will not only be diagnostic of malignancy but may lead to identification of a hitherto undetected primary tumor.

Vascular "spider nevi" are seen often during pregnancy. They also appear in great numbers on the skin of patients with liver disease, particularly cirrhosis. Hereditary hemorrhagic telangiectasia on the skin may occasionally provide a clue to the explanation of severe bleeding from the gastrointestinal, respiratory, or genitourinary tracts.

Signs of Blood Dyscrasias

Dermatologic lesions may accompany various blood dyscrasias. In polycythemia vera the face often shows a rosacea-like picture. Purpuric lesions call for a diligent search for etiologic factors; the glossitis of pernicious anemia is well known; leg ulcers are common manifestations of sicklemia; and persistent eczema of the neck is seen frequently in anemic patients.

Cutaneous lesions are common in the leukemias, lymphosarcoma, mycosis fungoides, Hodgkin's disease, and Kaposi's sarcoma. In some cases of leukemia an early finding is hypertrophic gingivitis, which must be differentiated from the gingival hypertrophy seen in pregnancy or after the use of certain drugs such as diphenylhydantoin. Occasionally biopsy of a cutaneous lesion has shown the diagnostic histopathologic picture before a diagnosis could have been made from the peripheral blood or a smear of the bone marrow. Cases have been studied in which the cutaneous, hematologic, and histopathologic pictures have varied, so that at one time a diagnosis of lymphosarcoma could be made, at another lymphocytic leukemia. A biopsy should be performed in all cases of exfoliative dermatitis, for sometimes a generalized erythroderma is an early manifestation of lymphoma as is herpes zoster, especially the hemorrhagic type.

Signs of Collagen Diseases

In the large group of so-called collagen diseases cutaneous lesions are important in leading to correct diagnosis of internal disease. Lupus erythematosus, dermatomyositis, and scleroderma are dissimilar in their clinical appearance and histopathologic features; yet they probably have in common the involvement of the collagenous tissue, and time may yet produce some common etiologic factor for all. The role of autoimmunity is being stressed at present as a possible etiologic factor in the entire group.

In pseudoxanthoma elasticum there are changes in the elastic fibers of organs other than the skin, and these may produce angioid streaks of the retina and may also be responsible for the development of hypertension, diabetes mellitus, gastrointestinal bleeding, and profound vascular disturbances throughout the body.

The cutaneous lesions that accompany sarcoidosis may be small papules or large disfiguring masses. Lesions may also involve the parotid gland, lymph nodes, eyes, bones, and especially the lungs.

Signs of Metabolic Diseases

Diseases that are errors of metabolism are often brought to light by the cutaneous lesions they produce. In porphyria there is extreme light-sensitivity, the photosensitizing agent probably being a derivative of hemoglobin; the patients develop hirsutism, bullae, and heavy pigmentation on the exposed parts, and a frequent association with diabetes mellitus has been observed. The tophi of gout, lesions of calcinosis cutis, amyloidosis, and myxedema are often diagnosed on gross inspection or on biopsy.

The xanthomas are the most common lesions in this group and their diagnosis is generally apparent on simple inspection. In every patient with a xanthoma a thorough investigation should be made. In many can be found profound changes in the chemical content of the blood and often a great increase in cholesterol and its esters or in fat. Many of these patients are candidates for hypertension, diabetes mellitus, or coronary disease. It is a grave error to treat patients locally for xanthelasma, for example, and to ignore the profound underlying pathologic processes that may have been responsible for producing the cutaneous lesion.

In diabetes one occasionally may also see, particularly on the legs, the yellowish-brown sclerotic patches of necrobiosis lipoidica diabeticorum. These can be diagnosed grossly and on biopsy and may uncover an unsuspected diabetes mellitus. Diabetic patients may also develop trophic ulcers at points of pressure.

Diabetics, with their low resistance to infections, are prone to develop boils and mycotic infections. A very common infection by *Candida albicans* produces lesions of erosio interdigitalis saccharomycetica, chronic paronychia, perleche, moniliasis under the breasts, on the vulva, about the anus, and on all the folds of the skin. In every case of boils and *Candida* infection, urinalysis and if possible a chemical examination of the blood should be made. In addition, patients with recurrent and resistant boils should be examined for a possible underlying hypogammaglobulinemia.

While Bockhardt's impetigo is a superficial folliculitis generally of little consequence, occasionally these lesions may be followed by a nephritis or even sepsis when the infection does not remain confined to the skin. Conversely, in cases of ulcerative colitis large undermining ulcers may develop in the skin, and their course is often parallel to the activity of the colitis.

Signs of Fungal Diseases

Of the deep fungal infections, histoplasmosis may manifest itself in lesions in the mouth or on the skin, while blastomycosis and coccidioidal granuloma may produce cutaneous lesions that explain hitherto baffling systemic symptoms. In a recent patient, hemoptysis and a lesion in the lung suggested the presence of a bronchogenic carcinoma. Fortunately the patient developed a pustule on the nose before any surgical procedures were carried out, and *Blastomycetes* in the pustule led to the diagnosis of blas-

tomycosis of the lung.

Other Signs

The characteristic lesions of tertiary syphilis or the scars that are left may lead to the diagnosis of late visceral syphilis. Tuberculosis also involves the skin.

Juxta-articular nodes should be explained. These firm masses that are seen at the joints may be associated with rheumatoid arthritis, but they may also be manifestations of xanthoma, leprosy, late syphilis or gout. A biopsy is often necessary for final diagnosis.

A vivid landmark that serves as a reminder of some profound sudden illness is seen in Beau's lines on the nails. Coronary infarction may produce these transverse ridges or discolorations as may pneumonia or any other serious illness. Clubbing of the finger nails is often seen in chronic pulmonary diseases, heart disease, and pulmonary or mediastinal tumors.

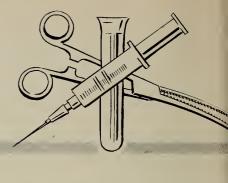
Structural changes in the skin that may be associated with internal disease are adenoma sebaceum with tuberous sclerosis of the brain, cutis verticis gyrata with diseases of the pituitary gland, port-wine marks occasionally associated with calcified lesions in the brain and neurofibromatosis with changes in the central nervous system.

Conclusion

These dermatologic lesions are but a few of those occurring as a result of internal diseases. It must be remembered that the skin is also of great diagnostic importance in the acute exanthemata, the erythema group, many systemic infections, allergic diseases, vitamin deficiency states, reticuloendotheliosis, endocrine disturbances, a great variety of drug eruptions, and self-induced eruptions.

A former medical colleague once accused me, as a dermatologist, of being interested in patients only down to the depth of one millimeter. That statement was a good example of the truism that those who are "down" on dermatology are so minded only because they are not "up" on it. There is indeed much more to dermatology than meets the eye, unless that eye has been trained to recognize the dermatologic manifestations of internal diseases.





COOK COUNTY HOSPITAL

Cardiac Arrest

Moderator:

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Director, Department of Surgical Education,

Cook County Hospital

Discussants:

VINCENT J. COLLINS, M.D.

Director, Department of Anesthesiology,

Cook County Hospital

ROBERT J. BAKER, M.D.

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Dr. Robert J. Freeark: The problem of cardiac arrest is of greatest concern to the surgeons and anesthesiologists involved with it in the operating room. That it is not exclusively a problem of the operating room has long been recognized though only recently has therapy been attempted. Efforts to deal with sudden death have been undertaken both successfully and unsuccessfully on the wards, in the outpatient clinics, admitting room, x-ray department, and in other areas of this hospital. The diverse medical interests represented at this conference today undoubtedly attest to the magnitude and seriousness of this problem. It is both gratifying and appropriate that nursing and all the medical and surgical specialties involved review its management.

The case we have selected is one of cardiac

arrest outside the operating room. The patient was admitted to the medical service, and the major portion of his care was carried out with the rather limited facilities that exist on a medical ward for the management of such a disaster. To discuss this problem we have invited two members of the hospital staff who need no introduction to most of you.

Dr. Vincent Collins recently joined the staff of this hospital after a distinguished career as director of the department of anesthesiology at Bellevue Hospital in New York, where he also served on the faculties of New York University School of Medicine. He has authored several textbooks and innumerable contributions to surgical and anesthesiologic literature and is chairman of the Section on Anesthesiology of the American Medical Association. His wide experience and deep concern over this problem of cardiac arrest will become quickly apparent. The procedural outline which we will distribute was prepared by him and his excellent staff.

Dr. Baker, throughout his nearly ten years of County Hospital experience, has developed a keen interest in this problem from the standpoint of the surgeon. He is eminently qualified to discuss the contributions of the surgeon to the causation and treatment of cardiac arrest, and his extensive experience in parenteral therapy and fluid and electrolyte disorders should prove particularly valuable. I have

asked Dr. Bransky to read the admittedly brief clinical abstract of this case. He and others of our surgical staff were called in at the point when open thoracotomy was elected.

Case Presentation

Dr. Ralph Bransky: This 65 year old oriental male was admitted in a comatose state to male medicine. A note from a local physician suggested an overdose of barbiturates had been ingested.

On physical examination the patient was well developed, well nourished, and in profound coma. The skin was warm and dry, blood pressure was 110/60, pulse 100, and respirations 8/minute. The corneal reflex was absent, and the pupils were pinpoint in size. The respirations were grunting in nature, tending to obscure breath sounds, rales, or wheezes if present. The heart was not enlarged, had a sinus rhythm, and was free of murmurs. The abdomen and extremities were not remarkable. Deep tendon reflexes were reduced but symmetrical throughout. Pathologic reflexes were not elicited.

Laboratory study on admission revealed a hemoglobin of 14 Gm./100 ml. and WBC of 15,500. The nonprotein nitrogen was 22 mg./100 ml., fasting blood sugar 100 mg., and CO_2 of 40 vol. per cent. An EKG showed combined ventricular hypertrophy. Urine obtained by catheter was free of albumin, sugar, and abnormal sediment.

Emergency treatment included a gastric lavage. The patient was started on intravenous fluids, and a series of respiratory stimulants were begun with slight success. By ten hours after admission the respiratory rate had increased to 16 per minute, but the patient remained deeply comatose.

Repeat physical examination at that time revealed decreased breath sounds over the right chest, and a bronchial obstruction was considered.

During the examination the patient suddenly stopped breathing, and there was a complete cessation of visible, palpable, or auscultatory signs of life.

The following measures were instituted:

- 1. Closed chest cardiac massage
- 2. Mouth to mouth respirations

3. With the return of feeble arterial pulsations at the femoral area but no detectable blood pressure, a series of drugs were begun which included Cedilanid-D[®] and Levophed[®].

Subsequently an endotracheal tube and assisted respirations were begun. Failure to restore consistent or sustained cardiac action prompted thoracotomy and open cardiac massage.

DR. FREEARK: The patient was in one of the side rooms over in the male medical building. Cardiac arrest occurred during examination. I believe Dr. Kushner of the medical attending staff was making rounds then, and the events that ensued, while somewhat hazy in detail, are similar to what is encountered in most such cases. It is our intention to try to apply to an event in the ward the well established principles for handling the situation in the operating room. We will not concern ourselves with the primary illness of this patient, the differential diagnosis, nor the treatment of drug-induced coma.

Suppose we let Dr. Collins lead off.

DR. VINCENT J. COLLINS: As Dr. Freeark suggested, let us review some of the principles established for such a situation in the operating room. With an understanding of the therapy of cardiac arrest under such ideal conditions, we can then apply these principles to situations outside the surgical theater.

There are three primary prerequisites to successful resuscitation methods: (1) an awareness of the situation and an ability to make the correct diagnosis; (2) a sense of time—there are four to seven minutes in which to institute effective therapy; and (3) a preconceived plan of action before serious brain and heart damage occur. The rehearsed plan is an essential because of the chaos that so frequently accompanies sudden death.

Diagnosis is usually self-evident. A state of cardiac circulatory collapse is based primarily on clinical observation. Whenever there is sudden disappearance of blood pressure and pulse, you must assume that there is a "cardiac arrest." Three conditions can exist: The heart may be in asystole; it may be fibrillating; or it may be so feebly contracting that the output

is not sufficient to create a pressure or pulse. In the operating room we are in a good position to check a major vessel because the surgeon is usually in a major cavity, and the aorta or any large vessel can be directly palpated. Lacking this, one can palpate the carotids. If there is no pulsation, one has corroborative evidence of arrest. But don't spend time on more refined diagnosis. Don't send someone for an electrocardiographic machine to determine the exact problem. What is necessary now is to institute active restorative measures.

Many of the precipitating factors are the same during surgery and outside the operating room. Hypoxia is the common denominator in cardiac arrest. The myocardium is deprived of an adequate amount of oxygen. Some contributory factors in arrest are certain anesthetic agents or hypersensitivity to a dye, such as may occur in the x-ray department or outpatient clinics. Hypoxia may be induced by anemia or blood loss. Pooling of blood on mobilizing a large abdominal tumor or embolism may be a factor. Postural changes such as shifting a patient in bed may be causative; for instance, a woman with a large ovarian cyst is shifted in bed, and the tumor shifts within the abdomen so that this sudden release of compression of the splanchnic veins combines with interference of return from the legs, and cardiac arrest is precipitated. Exaggerated and usually unnecessary positions also may be factors. Vagal reflexes are occasionally involved. Many other possible mechanisms may be involved.

A plan of action is crucial. In the operating room you must have basic facts in mind and the courage to do something. Outside the operating room you must have judgment as well as courage because usually the arrest occurs in a patient with a serious organic disease that greatly jeopardizes chances for recovery. The conditions are poor and the facilities usually so inadequate that in most instances the chest should not be opened.

Resuscitive efforts are directed toward the restoration of the oxygen systems of the body. The plan of action is divided into two phases: (1) the immediate or artificial oxygenation phase; (2) the delayed phase in which restoration of spontaneous action is the objective. Both artificial respiration and artificial circula-

tion are necessary. Sometimes in a ward or operating room we see someone massaging the heart without anyone breathing for the patient. This is ridiculous. The first step is to start ventilation. Sometimes this in itself is sufficient to restore the heartbeat. Jacoby has shown that rapid positive-pressure respiration of 30 to 50 times a minute, as might be achieved by squeezing an anesthetic breathing bag, is sufficient to cause enough compression of the myocardium to produce a cardiac output of 10 to 15 cc. of blood. Sometimes this is sufficient to oxygenate the critical tissues, including the myocardium. Thus the first step is to start breathing for the patient.

Any method of artificial respiration is ineffective if there is obstruction. The major cause of obstruction is the tongue. In the patient who is comatose the tongue tends to fall back and obstruct the airways. A simple maneuver is usually effective: The tongue is attached to the mandible and when the jaw is moved forward, the tongue will move forward away from the pharynx, thus providing a clear natural air passage. It may be necessary to use an artificial airway. A simple pharyngeal anesthetic airway is useful; an "S-shaped" double anesthetic airway permits mouth to mouth breathing. These are now present at all critical areas throughout this hospital. With a little practice they are easy to insert and represent a life-saving measure. If the patient has some other cause of obstruction in his mouth, remove it. Such foreign bodies as a chew of tobacco, dentures, or bubble gum are occasionally seen. Vomitus and blood should be cleaned out of the mouth. Preparing the air passage must precede the efforts to inflate the lungs.

Simultaneously other measures should be instituted, aimed at artificial circulation. In the operating room if the surgeon is in the abdomen, there should be no delay in getting into the chest and restoring circulation. The rate of cardiac compression has been shown by Kirby to be directly proportional to the systolic blood pressure. Compressing the heart at a rate of 60 times a minute will produce a systolic pressure of 60, whereas a rate of 80 will produce a pressure of 80 mm. Hg. However, a rate of 60 to 70 is practical; it is sufficient to provide a perfusion pressure adequate for the heart, brain, kidney, and lung. Since this is a very fatiguing task,

another physician should serve as a relief man after 10 minutes.

The technique of massage should be practiced on a cadaver or in a planned course of cardiac resuscitation using dogs. Every surgeon and anesthesiologist should get the feel of a flabby heart and should know how it feels when it is full and when it is empty.

Once direct cardiac massage (compression) has started, the diversion of a larger share of the blood from the heart to the cerebrum and the myocardium is important. This can be facilitated by putting a clamp on the thoracic aorta at its lowest point. It can be left for as long as 15 minutes. Another maneuver is to place the patient in a slight head-down position; at an 8° head-down position gravity will help drain secretions from the tracheobronchial tract and will encourage cerebral arterial flow.

Atropine should be given when reflex stimuli may have been responsible for the arrest. Resort to intraarterial transfusions is a debatable procedure. The Russians have reviewed this technic and believe it is a valuable way to handle cardiac arrest. It is true that there is an old physiologic principle that if you restore a significant amount of pressure in the aorta, there are reflex responses which restore a normal cardiac pattern. But this is a controversial area. Once control of the oxygenation of the body is achieved by artificial means, one must turn his attention to establishling spontaneous cardiac activity.

Now we embark upon the delayed phase of the resuscitation effort. It is necessary to know whether the initial condition was fibrillation or asystole. All authorities in the field have stated conclusively that epinephrine must never be injected blindly or routinely and must not be injected into the myocardium.

Asystole represents about 70 per cent of the cases of cardiac arrest. In asystole, epinephrine is indicated. The injection must be in the ventricular or auricular cavity, preferably in the right ventricular cavity, and the solution must be dilute. The reason we recommend the right ventricle is so that with the passage of this potent drug through the lungs during massage it will be further diluted, and by the time it eventually gets out of the left ventricle into the aorta and thence into the coronaries, it will be

dilute enough not to produce any excessive stimulation.

A standard ampule has a 1:1,000 solution, i.e., has 1 mg. in 1.0 cc., and this must be diluted 10 times to make a 1:10,000 dilution. In every 0.1 cc. you have 0.1 mg. or 100 micrograms. This is still a very highly potent and concentrated solution. Using 1:1,000 solution will only create adverse conditions in the myocardium and precipitate fibrillation. Generally, epinephrine is most effective when accompanied by calcium chloride. In repeated doses epinephrine alone quickly loses its capacity to stimulate the cardiac mechanism. Administration of fractional doses of 10 per cent calcium chloride eliminates the difficulty.

I think we have a better drug today than epinephrine: isopropylarterenol (Isuprel®). This also must be used in a dilute solution. The disadvantage of epinephrine is that it releases potassium in sufficient quantities to produce asystole. Isopropylarterenol does not; yet it has the same physiologic action on the myocardium as does epinephrine.

The second main circumstance of cardiocirculatory collapse in the operating room is ventricular fibrillation. This is easily treated, While massage and respiration continue, a defibrillator is obtained. The electrical requirements of such a device are simply based on Ohm's law. The heart has a 55 to 90 ohms resistance. A voltage of 120 to 130 volts and a current stimulus of about 1-3 amperes is applied directly. The technique is to shock the fibrillating heart sufficiently to produce asystole. The administration of cardiac sedatives may be necessary. Procaine is perhaps best. The dosage is between 100 and 250 mg. or 10 to 25 cc. of 1 per cent solution. This can also be used outside the operating room. When closed chest massage is being carried out, it is given intravenously not subcutaneously nor intramuscularly.

In making the diagnosis, usually the anesthetist is in a position to recognize the arrest. He should not hesitate. This is the time to inform the surgeon of an impending disaster, the time to get assistance. It is better to cry wolf than to have a patient die who could have been revived. Each member has specific duties. The anesthetist must position the patient, start vigorous artificial respirations, and order the ap-

propriate medications. The surgeon must open the chest and institute effective artificial circulation. The nurse must provide equipment, appoint a timekeeper and recorder, note what is given and when, minute by minute. This information is needed to know and assess the results. The surgeon has a definite duty, the anesthetist has a definite duty, and the nurse has a definite duty.

There are some don'ts. Do not use epinephrine when you have fibrillation. If fibrillation has been stopped, leaving a flabby myocardium, administer digitalis. Don't wait for an electrocardiogram. Prompt action is necessary without this refinement. Don't simply compress the chest to achieve pulmonary ventilation. Use mouthto-mouth breathing with a mechanical airway if necessary, or better, use a mask and bag like the small valvular breathing bag called the "ambu."

Outside the operating room we are going to be faced with natural deaths, not the iatrogenic deaths of the operating room created by combined surgical-anesthetic conditions; in these circumstances, we have an opportunity to achieve survival, and the conditions are ideal. But outside the operating room, a coronary occlusion or overwhelming pneumonia or septicemia may cause chronic stress on the myocardium so that it is incapable of responding fully. When such a heart stops, it is very resistant to therapy and usually stays stopped. How far should one go in his attempt to revive the patient? There is the real problem of a patient becoming decerebrate because of the treatment given. Do we have an obligation to proceed with extraordinary measures to try to sustain life in a hopeless situation when we are unlikely to restore a patient to a full life? This is a question which can be debated at great length.

Dr. Freeark: Dr. Baker, what role does the surgeon play in arrests outside the operating room?

DR. ROBERT J. BAKER: Dr. Collins has covvered comprehensively all the major points in resuscitative efforts, both in and out of the operating room. The 4-minute figure is one that deserves constant emphasis. There is a time limit beyond which effective resuscitation can rarely be successful. After 4 minutes, resuscita-

tive efforts are usually rewarded with a vegetative individual or a fatality; therefore early recognition is the single most important element of management of cardiac arrest, regardless of where it occurs.

Anoxia is a serious insult, not only to the brain but to the heart as well. The anoxic myocardium easily develops fibrillatory movements. These are totally ineffective in maintaining circulation. All attempts to correct fibrillation will fail, however, if you do not reoxygenate the myocardium. Therefore, it is impossible to defibrillate an anoxic myocardium. Every effort must be made to supply the patient's lungs with oxygen and restore, manually, enough cardiac action to carry the oxygen from the lungs into the coronary arteries.

Outside the operating room there is nothing better available for oxygenation that mouth-tomouth breathing. This is no time to be delicate. This life-saving measure is one which you must be willing to undertake, and mouth-to-mouth breathing means just that. If you look for a mask or an S-shaped airway, or some other mechanical device, you will be too late. There may be more esthetic ways to administer oxygen, but you are wasting time, and before long the patient will be irretrievable. Perform mouthto-mouth breathing by first pulling forward on the lower jaw with the thumb of the left hand; then hook the thumb into the mouth and pull forward or toward the ceiling. Closure of the system is accomplished by pinching off the nostrils with the thumb and index finger of the right hand. You then forcefully exhale or blow into the patient's mouth. The somewhat reduced oxygen content of the resuscitator's breath is not significant. If you have an assistant, and it is a good idea to find someone, have him put pressure on the epigastrium to prevent the stomach from becoming distended.

With regard to the massage you undertake for a heart that is arrested, there are a few prerequisites to success. First, you must have a salvageable patient. If you attempt to resuscitate a patient in profound anemia, or with far advanced carcinoma, or one who has had several episodes of coronary artery occlusion, it is usually fruitless. If you do succeed in resuscitating such a patient, you and the family may regret it. Resuscitation is advisable when you know the patient's general condition or that his illness is a recent and reversible one. The question then arises, Is closed massage better than or preferable to open massage? For arrest occurring outside the operating room closed massage in most cases is definitely preferable. Let us review again the technique of this closed chest massage.

Any massage that is instituted must be done under certain conditions. The patient must be flat on his back on a hard surface. If you have a patient in a soft bed, you cannot administer cardiac massage; pressure applied to the sternum only pushes the patient up and down; such activity will not move the sternum and apply pressure to the heart beneath. Therefore, the patient must lie on an unyielding surface. Put him on the floor or transfer him to a cart.

The pressure that is applied should move the sternum between 2 and 4 cm. The object is to compress the heart between the sternum in front and the vertebral column behind. This force must be administered with two hands, the palm of the left on the lower portion of the sternum and the palm of the right hand on the dorsum of the left, pressing straight downward. It can be applied too vigorously or not vigorously enough; if it is not vigorous enough, there will be no palpable pulse, and the resuscitative effort will have been wasted. Someone must be able to feel a carotid pulse. If the massage is too vigorous, you may have an accident which varies in severity from fracture of the ribs and sternum to rupture of the liver, diaphragm or lung. So do not try to approximate the sternum and the vertebral column. Once a pulse is obtained, that is the optimal amount of pressure, and further increase in pressure is unnecessary.

Cardiac massage and artificial respiration will effect resuscitation in a patient with cardiac standstill. It will also effect oxygenation of the myocardium in a patient who is fibrillating. Most patients with heart disease or an electrolyte problem promptly fibrillate after anoxia, and that can be detected only on an electrocardiogram; so the electrocardiographic machine must be obtained and the presence of fibrillation definitely determined. No amount of massage will resuscitate the patient until arrest of fibrillation is achieved and a spontaneous rhythm is established. Ordinarily, a defibrillatory agent will have to be applied, which is

electric shock. The disadvantages of this are that you may burn the chest wall, you usually get severe muscular contractions, and certain other things may occur. With the chest intact, it is possible to achieve resuscitation although an external defibrillator is required.

A word of caution is in order about internal defibrillators. There are several cases on record of surgeons who defibrillated patients' hearts, and had to be defibrillated themselves because they inadvertently made contact with the electrode and electrocuted themselves. I would discourage you from holding the electrode in your hand; be sure to use insulated handles. It is a life-saving but potentially dangerous device, and you must exercise care in its use.

I will not go into drug therapy further, but I would like to mention one other physiologic factor. The only reason that massage of any kind is effective is the fact that the human heart always arrests spontaneously in diastole. It is always flabby and, when squeezed, the size of the ventricle is effectively lessened, thereby squeezing blood out of it. When you release the pressure, the heart will fill again. Many times we have squeezed, defibrillated, or otherwise manipulated a heart which is feebly beating, but definitely not effectively enough to perfuse vital organs. This, for all practical purposes, will ultimately result in a fibrillating state or standstill unless oxygenation of the myocardium is reestablished. If you open the chest when the heart is only feebly or intermittently beating with a sinus mechanism, you have not made a mistake because the chances are good that the patient will not survive such a state, but will go on quickly to arrest. Usually the administration of calcium chloride and manual assisting will serve to restore effective cardiac action.

DR. FREEARK: It is not difficult to understand reluctance to employ direct mouth-to-mouth resuscitation technique at the County Hospital. In all of the wards and emergency areas the hospital has provided one of the S-shaped airways. Such a Resuscitube was available on the ward where this patient was being cared for, but it could not be located by the personnel on duty. That is the fault of the medical staff on such a ward. It is the responsibility of the physician to find out where that tube is and insist that it be kept in an imme-

diately available location. It is a valuable and far more acceptable means of resuscitation when it is available.

You will note that both of our discussants this morning have discouraged heroics. I think in the case under discussion the measures instituted were appropriate. The patient was stable up to the moment of sudden arrest and presumably had a reversible primary disease state. There was a suspicion that this arrest was related to an acute bronchial obstruction, but unfortunately the pathologic findings at postmortem examination failed to confirm this impression.

I am reminded of some similar heroics by a surgical resident on the pediatric service several years ago. Another member of the hospital staff had undertaken the administration of a local anesthetic without proper supportive equipment which resulted in cardiac arrest. The surgical resident passing by grabbed the first available knife and proceeded to open the chest as he instructed a nurse on mouth-tomouth breathing. It was estimated that the period of arrest was 6 to 7 minutes. They successfully restored cardiac action, but the child remained profoundly comatose for several weeks. During the next six weeks his behavior fluctuated between that of an "animal" and a vegetable but, nevertheless, slowly over the next six weeks he recovered and subsequently walked out of the hospital, perfectly normal in all respects. At the time we were all highly critical of the salvage efforts in such a seemingly hopeless situation. This indicates that in certain instances heroics are in order even though prospects for salvage seem remote.

As Dr. Collins talked, I could not help thinking of the arrests I have participated in and observed. We have all, at some time, disregarded many of the points he emphasized. It is a common practice, for example, to plunge a needle into the heart with adrenalin. We all fail to dilute the drug. We put it in the heart, but we don't know whether the heart is arrested or fibrillating or whether the medication enters the myocardium or ventricular cavity.

The head-down position of 5-10° is another common omission. Most patients with circulatory collapse are placed in a severe Trendelenburg position that make them difficult to move and treat. Moreover, any resulting improvement in cerebral arterial flow is more than negated by the interference with cerebral venous return.

DR. BAKER: The case Dr. Freeark cited is a not uncommon experience in a child. Children are much better able to tolerate cerebral anoxia than are adults. This is in contradistinction to what you would expect, but for some reason or other this is the case. There is a report in the literature of a child resuscitated after 11 minutes of arrest, but such cases are very rare. I think they validate the instruction, "When in doubt resuscitate." I should point out that neither Dr. Collins nor I meant to imply that after four and a half minutes have passed you should just sign the death certificate. If the patient is young, you may be rewarded with success after even a longer period of anoxia.

Dr. Collins: Note that in the case Dr. Freeark mentioned it was an iatrogenic situation: local anesthesia and heart standstill. This is a salvageable situation. What I would discourage is the practice of opening the chest and similar heroics in the chronic disease situation. Dr. Beck has made clear the point that the chronically hypoxic heart or the heart compromised by pre-existing organic disease cannot be revived. He has said that the arteriosclerotic heart which stops in the operating room cannot be revived. I know of no case in a large collection of available cardiac arrest reports in which the arteriosclerotic heart has been revived and the patient left the hospital. When uremia or pneumonia or several myocardial infarction's have occurred, the situation is different from a sudden cardiac standstill in a young person. When cardiac arrest is preceded by local anesthesia and happens suddenly, everything is favorable for successful treatment, and we institute all appropriate measures.

In our experience with 32 cases outside the operating room, however, we have had no success. One report describes the case of a doctor walking out of the lobby of a hospital and suffering a coronary occlusion. His chest was opened and massage started. There is little doubt from careful analysis of the case that he did not have a cardiac arrest since his heart was beating all the time. When I have my coronary, don't open my chest if cardiac arrest is diagnosed.

DR. HYMAN: Does the heart block occurring in Stokes-Adams syndrome constitute a diagnostic or similar therapeutic problem?

DR. COLLINS: Dr. Bryan has had several experiences with Stokes-Adams syndrome. Usually the patients are already known to have it and when the arrest occurs, simple measures can be instituted. Sometimes a sharp, severe blow on the chest is effective. You do not have to open the chest of these patients in most instances. Closed chest massage can accomplish the same result. Stokes-Adams is a salvageable situation, but simple measures only need be employed.

DR. FREEARK: In the patient presented today the first thing that was done was an attempt to bring his blood pressure up with the use of Cedilanid. This was not effective, so Levophed was reached for. Would you like to comment upon the appropriateness of the much abused and much used Levophed?

Dr. Collins: This vasoconstrictor is a most abused drug and is used in too high a concentration and in too many inappropriate conditions. It has a number of bad effects. It may raise the blood pressure but only at the price of generalized vasoconstriction. Every vessel in the body, including the coronaries and the renal vessels, are constricted. You may establish a blood pressure and circulation, but the patient is liable to die three days later from renal shutdown. Renal vasoconstriction is so intense from a small dose that it continues for almost two days, and renal plasma flow is decreased by 68 per cent. From our present state of knowledge, there are only one or two drugs that do not adversely affect the kidney, namely Methedrine® and possibly Metaraminol. In the administration of norepinephrine, it is hard to give the proper dosage. It is a difficult drug to titrate. One should use a dilute solution, and give it gingerly; but in a crisis there is excitement, an an infusion may run in quickly so that overdosage is frequent. One should be vividly aware of the ischemia and petechial hemorrhages in the heart and liver and kidneys which are produced by this drug. It has a necrotizing effect on most tissue of the body, and I believe it should not be used. There are other good drugs which have fewer toxic reactions.

QUESTION: May I ask you to comment on the use of potassium in a fibrillating heart outside the operating room?

DR. COLLINS: Chemical defibrillation is a recognized technique. A dilute solution of potassium chloride is used and carefully administered. We have had some success in the operating room with it. Only 4 or 5 mEq. will stop the normal heart completely. Usually 1 to 2 mEq. is sufficient to defibrillate if it is given in the cross-clamped aorta.

DR. BAKER: That is important. If you give it into the heart or intravenously, you give a large amount. The trouble with doing this in the closed heart is that it is difficult to eliminate the potassium from the myocardium once you get it in. You will then have difficulty starting the heart. Most people do not think potassium is as good for defibrillating as is quinidine.

Summary and Conclusions

In event of sudden disappearance of blood pressure and pulse the physician must assume that the heart has ceased to function and a state of cardiac arrest (asystole, fibrillation, or ineffectual contraction) exists. Since respiration will cease within a few minutes, the situation is one of cardiorespiratory arrest, and measures must be instituted to restore the total oxygen system and to reestablish spontaneous cardiac action.

Religion, properly understood, should be largely independent of seasons and places. There is something lacking in a religion which the summertime can destroy.—*Philip S. Watters*, *D.D.*



MEDICINE in the OUT-OF-DOORS

Cold Weather Survival

Julius M. Kowalski, M. D., Princeton

EACH WINTER SUDDEN STORMS stifle one or more areas in the northern tier of states, even occasionally wrecking havoc on the Mid-South. "New York Paralyzed by 16-Inch Snow Fall," "Chicago Slowly Digs Out," "Omaha - A Doomed City" are familiar news headlines and with accompanying photos illustrate our momentary helplessness against nature's onslaught. Because the term "blizzard" is reserved only for a meteorologic disturbance which meets specific criteria for wind velocity of at least 35 miles per hour, temperature of 20 degrees F. or lower, blowing or falling snow and restricted visibility, many snow storms are excluded from this definition but are equally disruptive to community activities. In our locale a blizzard can be expected every third year, but actually an interval of 9 or 12 years or more may pass without any, only to be followed by several in the succeeding 2 or 3 years.

In dazzling sunlight and bitter cold on the day after the storm as highway crews roll back the snow, the tragic aftermath unfolds. A mother and her two children are found dead in the snow-buried family car, apparently victims of carbon monoxide poisoning. The ignition switch was in the "On" position; gas indicator showed empty; and all windows were tightly closed. Or, the crew might clear a path to an auto askew on the highway but find no occupants. About half a mile farther they buck through a drift. The huddled figure of a dead man lies there. Only 12 hours before when his

car was stalled by the ever-mounting drifts, he set out afoot for the farm house he thought he passed a few miles back. Again, the crew might find an auto that skidded into a ditch from the slick pavement in the early hours of the storm. Within is a corpse — hatless, clad in light top-coat, no gloves, and only oxfords on his feet. The above descriptions and many similar ones with minor variations are reported each winter. In this era of sweeping toll roads, death stalks in winter's icy grip only a few miles from the comforts of home the same as it did a century ago when the lone horseman was trapped on the plains a hundred miles from the nearest settlement.

In the bastion of comfortable, well-heated and appointed present day autos, persons perish from cold exposure or carbon monoxide asphyxiation for lack of know-how or as a result of mental erosion. Panic ensues when the mind is robbed of sober thought. Then body energy disintegrates in aimless activity. For the average person the discomfort of cold, loss of contact with others as when isolated by a storm, the ancestral fear of darkness, and other groundless anxieties make for a psychological maelstrom.

Misinterpretation of observations and misjudgements are compounded one upon another until abject despair overwhelms one in the hostile environment. Less than 24 hours before, the unfortunate one was a well oriented being in the prime of health but now is struck dead for misappraisal of his seemingly untenable predicament. (continued on page 48)

tremity were lost. There was no sensory impairment.

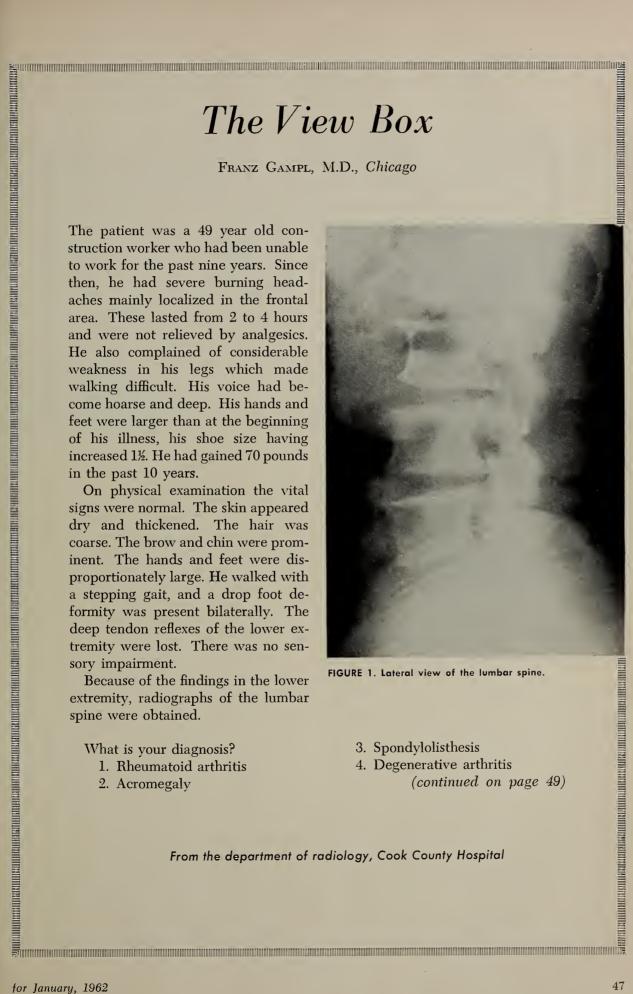
Because of the findings in the lower extremity, radiographs of the lumbar spine were obtained.

What is your diagnosis?

1. Rheumatoid arthritis

2. Acromegaly

From the department of radiology, Cook County Hospital



(continued from page 46)

The will to survive is present in all, but in some it is more tenacious. Faith, courage, and the will to live are terms tossed about daily without much context, but in a threatening situation, as every physician has witnessed, they may spell the difference between life and death. Knowing what to do or what not to do in given circumstances, and understanding some limits of human deprivation reinforce the will to survive, and this purposeful activity is the best shield against panic and mental deterioration.

As concerns starvation under the conditions of isolation by a winter storm, a person who has enjoyed normal health and nutrition will not succumb in 3 or 4 days or possibly a week. In many cases of starvation and exposure, dehydration plays a most significant role as in the desert, on the open sea, or in the arctic. But this is not too serious if it lasts for only several days. A well nourished individual can go without food for about 3 weeks; in many cases persons have gone much longer than that and survived. Mahatma Gandhi, striving for world attention in pointing up India's problem with the British, embarked on several self-imposed fasts which extended beyond 20 days. One was of 26 days' duration. He had absolutely no food in this time but did take sips of water. He expended very little physical energy, lying down much of the time and even limiting conversation to monosyllables.

In the arctic mid-winter, military personnel have survived in the wilderness for a full week without food at temperatures varying from 30 to 50 degrees below zero. Prior to the experiment they were given the usual high caloric diet that all other personnel in that command received daily. They had proper clothing and protective gear in the form of tents and sleeping bags. The average weight loss per man was 13 pounds, and the party treked back 16 miles to the base to conclude the experiment after seven foodless days. This demonstrates the stamina and survival ability of healthy, properly nourished and indoctrinated personnel. Comparable experiments are being performed regularly by ever increasing numbers in our military survival schools.

Eskimos have lived in a harsh environment for thousands of years. How do they protect themselves when caught in the open by a storm? They do the simple and obvious - stop and sit down. They know that to press on when all landmarks are obliterated and sense of direction is lost in the fury of a storm is sheer folly. They construct a shelter of sorts against a hummock of snow, dig out a trench, or use their sled. Whatever the shelter, it is covered with robes and furs to make a miniature igloo with the snow heaped upon it. It is all designed to trap air — the most effective insulator known. The clothing of Eskimos is covered with fur both inside and out. This too traps air. The knee-length parka and large hood trap the warm rising air from about the body. An upright position must be maintained as in sitting or squatting. To lie down horizontally would permit the warm air to spill out from around the body. Insulation in the form of furs is needed between the body and snow to prevent heat conduction. The storm heaps more snow on the shelter, and this then becomes a comfortable, makeshift abode.

Snow itself is an effective insulator containing countless tiny air pockets. A blanket of snow a foot thick can maintain a temperature differential of 20 to 30 degrees, depending upon its density, moisture content, age, and other factors. It was this knowledge among mountain men which repeatedly contributed to their survival when trapped by sudden storms in the high passes. They crawled under a snow-covered bush, often heaping more snow upon it, and squatted within until the storm abated. Thus they conserved heat and energy, collected their thoughts and in the clear of the following day unerringly made their destination.

The insulating qualities of snow aid the survival of many species of birds and mammals. Every country boy remembers the thrill of a grouse exploding from a snow bank where it had spent the night, or a rabbit bursting from beneath a snowy fence row.

The motorist with his car stuck in a snow drift can utilize this knowledge about the insulating qualities of snow. Heaping more about the car will prevent the dissipation of heat. An auto completely covered is like an igloo or a (continued on page 52)

The $View\ Box-$ diagnosis and discussion (continued from page 47)



FIGURE 2. Sella turcica.

The diagnosis is acromegaly. The radiographic findings in the lumbar spine consist of:

- 1. Widening of the intervertebral disc spaces
- 2. Increase in height of the vertebral bodies
- Concavity of the contour of the posterior surface of the vertebral bodies with spur formation at the posterior aspect of the endplates
- 4. Increase in the physiologic lordosis

Differential Diagnosis: Degenerative osteoarthritis shows asymmetrical narrowing of the interspaces and sclerosis of the endplates. The spur formation is prominent at the anterior and lateral aspects of the endplates.

A view of the sella turcica (Fig. 2) shows considerable enlargement, which is present in 90 per cent of the patients with eosinophilic adenomas. Typical acromegalic changes are also present in the hand (Fig. 3) with spading of the distal phalangeal tufts, thickening of the soft tissues, and hyperostoses of metacarpals.

There was an increase in uptake of radioiodine after administration of thyroid stimulating hormone, confirming the clinical diagnosis of secondary hypothyroidism. The neurologic findings in the lower extremity were due to a co-



FIGURE 3. Typical changes in the hand.

existing neuritis of the peroneal nerves (Charcot-Marie-Tooth disease).

Discussion: The radiographic changes in acromegaly are due to increased production of growth hormone. Its stimulating effect upon the periosteal and endochondral bone formation is responsible for the hyperostoses, spur formation, and localized overgrowth of the bony prominences. A less well-known but interesting feature of the disease is bone absorption. It accounts for enlargement of the paranasal sinuses, thinning of the shafts of the phalanges of the toes, concavity of the posterior aspects of the vertebral bodies in the lumbar region, and resorptive thinning of the parietal bones of the skull.

REFERENCE

Steinbach, H. L.; Feldman, R., and Goldberg, M. B.: Acronegaly, Radiology 72:535-549 (Apr.) 1959.

Perforation of Regional Enteritis into the Free Peritoneal Cavity

J. Major Greene, M.D., Saul Sorosky, M.D., Jack Zackler, M.D., and Earle I. Greene, M.D., Chicago

DR. James C. Neely, in a 1960 report¹ states, "Acute perforation with a diffuse spreading peritonitis is a rare and alarming manifestation of regional enteritis. Crohn has recently stated that 'free perforation of ileitis into the peritoneal cavity never occurs or at least I have not seen it."

Dr. Neely goes on to report four cases of perforation of regional enteritis into the free abdominal cavity and cites two others. We wish to report another case.

Case Report

Miss E. D., age 47, was hospitalized Dec. 6, 1952, with a six-hour history of acute pain mainly in the lower abdomen. Nausea and vomiting were present. A past history of a similar episode, or of previous nausea, vomiting, diarrhea, abdominal distention, cramps, or dark stool could not be obtained.

Her temperature, orally, was 101 F., pulse 120 per minute, blood pressure 120/80, the RBC 4,200,000 and WBC 11,000 per cu. mm. with a shift to the left. Urine examination showed no abnormalities.

Some abdominal distention was present, but bowel sounds were absent. Tenderness on mild palpation was found throughout the abdomen but was most severe in the lower right quadrant. Rebound tenderness also was most marked in the lower right quadrant. Rectal and vaginal examinations produced severe pain on the right side. No abdominal masses were delineated on examination.

A diagnosis of perforation of the appendix was made. Through a low right rectus incision the cecum and appendix were isolated and appeared normal except for some slight hyperemia of the serosa. On raising the terminal ileum, free seropurulent material was found in the ileocecal area. The terminal ileum for about 45 cm. (18 inches) was edematous, the serosa was hemorrhagic, and a small perforation was found on the free intestinal border. A diagnosis of regional enteritis with perforation into the free peritoneal cavity was made. The entire hemorrhagic, indurated terminal portion of the ileum and the cecum were resected, and the ileum was anastomosed to the ascending colon.

The pathologic report of the excised tissue was "Small intestines (ileum). Regional enteritis with perforation. Peritonitis, acute. Appendix: Periappendicitis, acute.

It is eight years since this patient had surgery, and she has had no gastrointestinal complaints.

Summary

Perforation of regional enteritis into the free peritoneal cavity may take place. This case report represents the seventh such case reported in the literature.

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Neely, J. C.: Perforation in Regional Enteritis, J.A.M.A. 174:1680-1682 (Nov. 26) 1960.

From the department of surgery, Mount Sinai Hospital, and the Chicago Medical School

Hemiaplasia of the Thyroid Gland

PHILIP SHAMBAUGH, M.D., Lake Forest, and VAIRA SHREERAM, M.D., Chicago

CONGENITAL ABSENCE of an entire lobe of the thyroid gland is a rare anomaly. As nearly as we have been able to determine, only 29 such cases have been reported. The largest series was published in 1933 by Pemberton and Mc-Caughlin, who found five instances of hemiaplasia in 45,367 operations on the thyroid performed in the Mayo Clinic during the preceding 40 years. The most recent report to come to our attention is that of Poate and Wyndham,² who in 1938 described two cases of hemiaplasia, both of which occurred in women with mild hyperthyroidism. A statistical analysis of 3,000 routine complete autopsies by Ophüls in 1926 disclosed one case of total agenesis and five instances of hemiaplasia of the thyroid. In this same study there were five cases with only one kidney, two with but one testicle, and one with no gallbladder.

Case Report

A healthy woman of sixty had noted gradual enlargement of the right side of the neck for several months with a slight choking sensation on swallowing. Examination revealed a firm, diffuse enlargement of the right lobe of the thyroid with no clinical evidence of hyperactivity. The blood pressure and urine and blood exami-

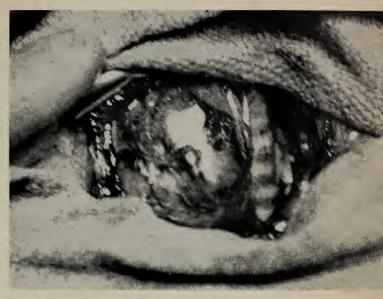


FIGURE 1. Photograph at surgery showing absence of isthmus and left lobe of the thyroid gland.

nations were normal. Surgery was undertaken for a presumed nontoxic nodular goiter.

Surgery revealed an enlarged, slightly nodular right lobe. Alongside this lay a completely bare trachea, and careful search of the left side of the neck revealed that, in addition to the isthmus, the entire left lobe of the thyroid was missing (Fig. 1).

In spite of this unusual finding, a subtotal resection of the right lobe was carried out because of its abnormal appearance and consistency. Approximately three grams of thyroid tissue was spared along the posterior capsule.

The removed specimen weighed 30 grams and on cut section showed red-tan surfaces with some nodularity. Microscopic sections showed large and small acini separated in many areas by masses of lymphoid tissue with many plasma cells, numerous germinal centers, and with marked fibrosis of the stroma indicating a diagnosis of Hashimoto's disease.

The patient made a prompt recovery and was discharged on the third postoperative day. She remained well without medication for two and a half years when she returned complaining of loss of energy and slight gain in weight. Since thyroid function tests disclosed a basal meta-

bolic rate of minus 17 and a PBI of 4 micrograms per cent, thyroid replacement therapy was started.

Discussion

Absence of the thyroid isthmus is not extremely uncommon, occurring in about 5 per cent of individuals; and the coincidence of aplasia of the isthmus with hemiaplasia of the gland is seen occasionally, although in most instances of hemiaplasia the isthmus remains. As in the case of other paired or bilobate organs, congenital absence is for some reason more common on the left side. Judging from the study of Ophüls,3 hemiaplasia of the thyroid is not as rare as the few published reports would indicate. This is probably because the condition cannot be diagnosed clinically and is revealed only when disease of the remaining portion of the gland leads to surgical intervention.

As far as we have been able to determine, the above described case is the only recorded instance of chronic thyroiditis or Hashimoto's disease found in the remaining thyroid lobe at surgery.

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 Poate, H. R. G., and Wyndham, N.: Hemiaplasia of the Thyroid Gland, M. J. Australia 2:514, 1938.
 Ophüls, W.: Statistical Survey of 3000 Autopsies, Stanford U. Publications Med. Sciences 1:3 (Nov.) 1926.

Cold Weather Survival

(continued from page 48)

mountaineer's bush shelter.

The source of comfort in every auto is the heater. But here is the death trap, claiming about 400 lives annually - persons who didn't know about carbon monoxide or thought, "It can't happen to me." True, it is a colorless, odorless, tasteless gas, but the point for all motorists to remember is that it is present in varying concentrations in the exhaust fumes of every engine. The acrid combustion products in auto exhaust fumes should be considered a stenching agent and a warning for the everpresent carbon monoxide. Whether the odor of fumes is perceptible or not, gas is present. Also, every auto exhaust system leaks fumes and carbon monoxide, regardless of its age or state of repair. A tail pipe blocked with snow as frequently occurs from backing into a drift will cause exhaust fumes and carbon monoxide to escape through seals or rust holes in the exhaust system from the motor block to the tail pipe. The fumes then easily waft into the car's interior.

The first symptoms of poisoning (and from very low concentrations at that) may be headache, incoordination, faulty vision, mental confusion, drowsiness, nausea or vomiting, or any combination of these. The average motorist

might mistakenly attribute such symptoms to fatigue or some other cause instead of carbon monoxide. Fresh air — oxygen — is immediately necessary as a first-aid measure. More severe gas poisoning is manifest by a cherry or dusky red color of the lips, pale skin, twitching of the face, and finally, unconsciousness. Artificial respiration and medical aid is then imperative.

Exercise for the stalled motorist is a necessary heat-producting activity. Shivering is an uncontrolled physiologic response to a cold stimulus for maintaining body heat. Deliberately paced exercises — slapping of arms across the chest, stomping of feet or any other effort short of perspiring — will keep the average person warm for hours.

If the winter motorist in snow areas always carries in his car a shovel, blanket, overcoat with ear muffs or shawl and gloves in it, a hat and galoshes, he is well prepared to sit it out. To walk for aid in a blizzard is to be lost, unless the distance is short and objective in sight. Farmers have died from exposure during snow storms in the few hundred feet between barn and house.

Your car heater should be used sparingly, and always with a window partly open. Exercise from time to time, keep your wits about you, be confident, squat upon the seat with blanket tented over vou. Eskimos have sat out far worse storms for centuries.

Parenteral Use of a Promethazine-Meperidine Combination During Labor*

August F. Daro, M.D., Harvey A. Gollin, M.D., Howard B. Brenner, M.D., and John L. Picchietti, M.D., Chicago

AN EARLIER REPORT¹ on sedation-analgesia in the first stage of labor described administration of promethazine and meperidine separately, in various dosages, by intramuscular or intravenous injection. Sedation and relief of pain were obtained with smaller than standard dosages of meperidine in a high percentage of the mothers, although some of them had been extremely excited and even hysterical before medication. No untoward effects developed in the parturient, fetus, or newborn; and the combination of premedicants was considered safe also for premature labor. As a sequel to the former study, the present investigation was undertaken to evaluate the sedative-analgesic potential and possible effect on the infant of a mixture of 50 mg. promethazine and 50 mg. meperidine prepared in one dosage form* for intramuscular administration.

Plan of Investigation

The series consisted of 405 unselected patients in active labor at at least 36 weeks' gestation. Twenty-five per cent were primiparas. About 90 per cent were 16 to 35 years old.

The emotional status and the severity of the pain at the time medication was administered were evaluated by two of the attending physicians; their clinical impressions of each patient were compared and were found similar in all cases. Ninety-five per cent of the patients were experiencing moderate to severe contractions.

Medication. Twenty-one patients (5 per cent) presented various indications for acceleration of labor: premature rupture of the membranes, 9; secondary uterine inertia, 5; primary uterine inertia, 2; pre-eclampsia, 4; and abruptio placentae, 1. Each of these received 10 units of a synthetic oxytocin (Syntocinon®) intravenously in 1000 cc. of 5 per cent dextrose in water.

As soon as the need of sedation and analgesia became apparent, promethazine and meperidine were administered intramuscularly in a dosage form containing a mixture of 50 mg. of each compound. No other sedatives or analgesics were used.

Blood pressure readings were taken one hour or more after administration of the promethazine-meperidine combination in 104 cases.

Evaluation of mother after medication. Approximately one hour after administration of the sedative-analgesic, patient toleration of contractions was again evaluated and compared with reaction to the pains before medication. If she showed (a) pronounced relief and was relaxed or sleeping between contractions, the response was graded as "good"; (b) a degree of relief and was quieted to some extent, the result was considered "fair"; (c) no improvement in pain status or emotional condition, "no effect."

Duration of labor. The lapse of time from onset of regular uterine contractions at five-minute intervals to delivery averaged 8 hours

From the department of obstetrics, Cook County Hospital, Chicago

^{*}Mepergan[®] Injection, promethazine hydrochloride and meperidine hydrochloride, available from Wyeth Laboratories.

TABLE 1. Emotional and Pain Status of Patients* and Sedation-Analgesia Produced by Combined Promethazine-Meperidine.

Condition	No. of		I	Response		No. o	f		Response	
Prior to Medication	Primip- aras		Good	Fair	No change	Multip aras	%	Good	Fair	No change
Sensorium										
Hysterical	4	(4%)	2	2	0	7	(2%)	5	0	2
Irritable	65	(64%)	31	26	8	153	(52%)	42	79	32
Relaxed	33	(32%)	15	13	5	135	(46%)	40	56	39
Total	$\overline{102}$		48 (47%)	41 (40%)	13 (13%)	295		87 (29%)	135 (46%)	73 (25%)
				87%	, ,			75	5%	, ,
Pain										
Severe	33	(32%)	12	15	6	110	(37%)	32	43	35
Moderate	65	(64%)	31	23	11	171	(58%)	66	75	30
Minimal	4	(4%)	3	1	0	14	(5%)	2	9	3
Total	$\overline{102}$		46 (45%)	39 (38%)	$\overline{17}(17\%)$	295		100 (34%)	127 (43%)	68 (23%)
				83%	, ,			77		,

^{°5} patients, no record of response; 3 patients, medication administered within 20 minutes of delivery, therefore no response.

TABLE 2. CRITERIA FOR APGAR SCORING OF THE CONDITION OF THE NEWBORN.

Sign	0	1	2
A. Heart rate	Absent	Slow — 100	100 and over
B. Muscle tone	Limp	Flexion of extremities	Active motion
C. Respiratory effort	Absent	Slow, calm, irregular	Good crying
D. Response to catheter in nostril after oral pharynx cleared	None	Grimace	Cough or sneeze
E. Color	Blue, pale	Body pink, extremities blue	Completely pink

in 279 multiparas (92 per cent); and 15 hours and twelve minutes in 92 primiparas (90 per cent).

Anesthesia. Regional anesthetics were used in all cases. Ninety-six per cent of the patients were delivered under pudendal block and 4 per cent under caudal or spinal anesthesia. Thus anesthesia was eliminated as a possible cause of depression in the newborn.

Delivery. Forceps were required for delivery in 57 patients (14 per cent of the total series) — 46 primiparas (45 per cent) and 11 multiparas (4 per cent). Midforceps were used in 6 of the cases and Piper forceps in 3.

Results

For 95 per cent of the total series, one dose

of the sedative-analgesic combination sufficed.

Eighty-seven per cent of the primiparas experienced good to fair sedation in 30 to 90 minutes after the intramuscular injection. Among the multiparas a similar response occurred in 75 per cent. As for analgesia, 83 per cent of the primiparas obtained good to fair relief; and of the multiparas, 77 per cent had comparable relief (Table 1). When the results for both groups were combined, the over-all sedative-analgesic response was good to fair in 4 out of 5 patients.

Blood pressure appeared not to be significantly influenced by the promethazine-meperidine mixture. The reading did not vary more than 15 mm. Hg systolic and 10 mm. Hg diastolic in either direction throughout duration

of the activity of the dose. After injection of a group of 104 patients from the series, there was a slight rise in pressure in 43 cases, a slight reduction in 47 cases, and in 14 there was no change. The time of taking the reading after injection seemed to have no influence on the blood pressure level. When the blood pressure was measured for 32 of the patients within one hour after the injection, there was a slight rise in 15 cases, a slight reduction in 14, and no change in 3.

Condition of the Newborn

There were 415 infants born of 405 mothers: 395 patients were delivered of single infants and 10 (2 primiparas, 8 multiparas) had twins. The status of the infant was evaluated 60 seconds after completion of the second stage, using the method initially proposed by Apgar in 1953. Table 2 shows the Apgar criteria for scoring the condition of the infant on delivery. The most favorable prognosis is represented by a score of 10, 9, 8 or 7; scores of 6 to 4 indicate mild depression, as from medication of the mother; and 3 to 0, severe depression.

The records showed no observation on the condition of the newborn in 11 cases. Of the 404 infants for whom the records were complete, 5 were stillborn (1 per cent). The condition of the 399 viable newborn is shown in table 3.

For the 399 viable infants the average Apgar rating was 8.3. Of the 20 twin infants, 6 were term size by weight. Delivery was spontaneous in 14 cases; the average Apgar score was 8.6 for this group. Total breech delivery was performed for 4 of the twin infants, and version and extraction of the second twin was done in 2 cases. The average Apgar score for these 6 infants was 6.6.

The average Apgar ratings after oxytocin acceleration of labor and after forceps application are shown in table 4. The average rating after all forceps deliveries was 7.9.

Table 5 shows the relationship of the Apgar score to the interval between medication and delivery. The distribution is even, and when the 6-5-4 scores are considered, it seems apparent that the medication did not exert any influence detectable with the Apgar method. A control would be necessary to validate this comparison.

TABLE 3. Condition of 404 Newborn* of Mothers under Promethazine-Meperidine Therapy for Labor.

Apgar Rating	Mother Primip- ara	Mother Multip- ara	Total	Viable Infants	%
10	15	78	93)		
9	40	97	137)	354 —	89%
8	28	58	86)		
7	7	31	38)		
6 5	6	12 8	18) 12)	32 —	8%
4	1	1	2)		
3 2	1 0	4 3	5) 3)	13 —	3%
1	0	4	4)		
0	0	1	1)		
C4:111	_	7 C .	stal gaming	399	

Stillborn — 5 or 1% of total series

TABLE 4. Average Apgar Ratings after Oxytocin Acceleration of Labor and Forceps Delivery.

	No. of Infants	Average Score
Oxytocin administered after		
premature rupture of membran	nes,	
without labor	9	8.2
Secondary uterine inertia	5	8.0
Primary uterine inertia	2	5.0
Pre-eclampsia	4	8.2
Abruptio placentae	1	stillborn
Application of outlet forceps	48	8.5
midforceps	6	5.1
Piper forceps	. 3	4.0

There were 2 neonatal deaths, the first ascribed to numerous congenital anomalies incompatible with life, and the second to transverse arrest with difficult midforceps rotation. This infant, who weighed 5 pounds, 14½ ounces, died three hours after delivery. The total fetal loss for the entire series was 1.7 per cent.

Discussion

The results obtained in the parturient using promethazine and meperidine prepared in a combined dosage form were generally comparable to those observed in the previous study.¹

The possible effect of the medication on the infant is more difficult to assess. However, we feel that evaluation is best done with the Apgar

^{*}Condition unrecorded for 11 infants.

technic. The over-all results are comparable to the figures reported by Apgar on 15,000 cases.

Forty-five infants (11%) received an Apgar score of 6 or less (Table 5). Of the mothers of this group, 12 received the injection more than four hours before delivery. Therefore it is unlikely that the predelivery medication had any influence on the lowered Apgar rating of the infants.

TABLE 5. Relationship of Apgar Score to Interval between Medication and Delivery of 399 Rated Infants.

Time of Medication		Apgar Score					
Prior to Delivery	6	5	4	3	2	1	0
0-15 min.	0	0	0	0	0	0	0
15-30 min.	1	0	0	1	0	0	0
30-45 min.	2	1	0	1	1	0	0
45 min1 hr.	3	0	0	0	0	1	0
1-1½ hrs.	1	0	0	0	1	1	1
1½-2 hrs.	3	0	0	0	0	1	0
2-3 hrs.	2	4	0	1	1	1	0
3-4 hrs.	2	2	0	1	0	0	0
More than 4 hours	4	5	2	1	0	0	0
Total	18	12	2	5	3	$\overline{4}$	$\overline{1}$
		32	(8%)		13	(3%)	

Of the other 33 babies, 13 received an Apgar score of 3 to 0; these must be evaluated more closely. The 1 infant scored as 0 was a premature double footling breech; Duehrssen's incisions and Piper forceps were required for delivery.

There also were obstetrical reasons for the low score assigned to the 4 infants with a score of 1. A difficult midforceps delivery accounted for 1, shoulder dystocia for another, and fetal distress in the first stage with passage of meconium in the second stage occurred in the third infant. In the fourth case oxytocin was administered for primary uterine inertia; precipitation of second stage labor resulted in traumatic rupture of the umbilical cord.

In Apgar category 2 there were 2 premature infants, both depressed at delivery after uncomplicated labor; and 1 child with multiple congenital anomalies who died within an hour of delivery.

In this manner 28 of the 45 infants who received an Appar rating of 6 or less were eliminated from the group because of obstetrical reasons sufficient to have caused the lower score.

Delivery was uncomplicated in the remaining 17 infants of the group; therefore the depression present possibly could have been ascribed to the medication. However, depression might have been expected in a certain percentage of such infants even though all predelivery medication was withheld. Resuscitative measures were used in 6. All of these responded in five to seven minutes, at which time they achieved an Apgar score of 9 or 10.

Summary

Under regional anesthesia, 405 mothers delivered 415 infants. A combination of 50 mg. of meperidine and 50 mg. of promethazine in one dosage form had been administered intramuscularly for sedation-analgesia during the first stage. One dose sufficed for 95 per cent.

Four out of 5 of the patients exhibited a satisfactory response.

The average Apgar rating of all infants in this series was 8.3. Ninety-seven per cent of the viable infants scored 10 to 4 (89 per cent, 10 to 7). One per cent were stillborn; 0.5 per cent died of obstetrical causes after delivery; the over-all fetal loss was 1.7 per cent.

The maternal blood pressure was not adversely affected by medication.

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When Neglect Is Good I know the pressure to "do something" is always there—but often the test of good medicine is to practice the art of intelligent, planned neglect rather than to treat when treatment is not necessary. Robert B. Lawson, M.D. The Art of Intelligent Neglect. Consultant. July 1961.

MEDICAL—LEGAL



Medical and Legal Foundations for Justifiable Abortions*—An Abstract

SOLON N. BLACKMER, M.D., Chicago

A "STARTLING" Move to relax statutory bans against criminal abortion is revealed by the first installment of a two-part article in the Georgetown Law Journal of January, 1961.

The proposed revision is the more surprising, the article states, because:

- It is presented under the auspices of one of the nation's most influential legal societies.
- It comes at a time when the medical profession has all but ruled out therapeutic abortion as a necessary or justifiable lifesaving treatment of the complications of pregnancy.
- It would effectively license the activities of medical quacks and criminal abortionists, giving them the same authority as the most distinguished obstetricians.

Commenting on an abortion law drafted by the American Law Institute as a part of its proposed Model Penal Code, the author, himself a life member of the ALI, characterizes the statute as "a violent departure from all existing laws" and a denial of the traditional concern of all civilized societies since earliest times to protect the life of an unborn child.

Written by a Chicago attorney, Eugene Quay, the first installment, running 85 pages, is chiefly devoted to a review of the medical literature. The change in medical opinion on therapeutic abortion is traced from the turn of the century to the present by means of quotations from medical texts and periodicals. This is accompanied by an elaborate bibliography of medical literature relating to induced abortion. In the subsequent installment Mr. Quay proposes to examine the legal history of the question together with its present status, beginning with the earliest known codes and ending with a comparative analysis of American and English statutes.

Through an assemblage of notable medical witnesses, the author shows the building up of a long list of indications for therapeutic abortion and the gradual abandonment of one after another as extensive clinical experience demonstrated the greater effectiveness of nonsurgical treatment and as evidence accumulated indicating that in many cases abortion created greater hazards than those it was invoked to avert.

The ever-greater medical skepticism as to the value of therapeutic abortion, as exemplified in the statement of Dr. R. J. Heffernan, Tufts Medical College, that "Anyone who performs a therapeutic abortion today is either ignorant of modern medical methods of treating the complications of pregnancy or is unwilling to take the time to use them," and reluctance of physicians to use the legal sanctions for the measure now available to them are in contrast to the proposed provisions of the new Model Penal Code cited by the author.

These would "justify" abortion whenever two physicians declare in writing their belief that there is substantial risk that continuance of the

^{*}Original by Eugene Quay, LL.B., M.A., Chicago in Georgetown Law Journal, January, 1961

pregnancy would gravely impair the physical or mental health of the mother or would result in the birth of a mental or physical defective; and whenever the pregnancy resulted from rape or incest.

Noting that the opinion need not go beyond "belief" and that there is no requirement that the basis of such "belief" be stated, the author criticizes the proposed statute for its use without definition of general terms commonly employed in a variety of meanings.

The broad language of the statute could be interpreted to legalize termination of any pregnancy, however free of complications, the author believes, since even normal pregnancy holds some risk, however slight, of impairment of maternal health.

Moreover, the Model Code would not require that the doctors approving or performing therapeutic abortion be men acceptable to legitimate medical societies or having access to reputable hospitals, but only that they have still unrevoked state licenses. Neither of the two would be required to be an obstetrician, or an internist, or specialist, in the particular complication involved. Similarly, the procedure need not be done in an approved hospital but could be performed in the most dubious institution the state had not yet succeeded in closing. No provision is made for approval by a consulting committee such as have been voluntarily set up by many hospitals.

Thus, states the author, "physicians of the type that organized medicine is every trying to eliminate would have the same authority under the proposed statute as the most distinguished obstetrician or specialist in any of the complications of pregnancy."

In his exhaustive search of the literature, the author brings a great variety of witnesses to show the evolution of medical opinion in regard to such specific conditions as tuberculosis, heart, kidney, liver and thyroid ailments, hypertension, hyperemesis gravidarum, neoplasms, toxemia, diabetes, anemia, leukemia, epilepsy, asthma, chorea, multiple selerosis, myasthenia gravis, ectopic pregnancy, eclampsia, pre-eclampsia, and hydatidiform mole.

As one by one each of these indications diminished in importance or disappeared altogether in the wake of medical advances, psychiatric indications rose to take their place but today, these too are being seriously questioned, according to the authorities quoted.

More recently still, therapeutic abortion has been advocated for genetic reasons (still not sanctioned by law) to prevent the birth of possibly defective offspring in cases of maternal rubella or one complicated by the Rh factor. But here, too, medical scientists are beginning to revise their opinion and to seek other ways of combating the evils thought to arise on occasion from these situations.

Noting that there is no swelling demand from medical men for greater freedom to order abortions on medical grounds, the author indicates that those who wish to perform them must do so for nonmedical reasons — economic, social, or at the mere wish of the patient. The present pressure for legalized abortion is based on such considerations and largely comes, says the writer, "from involuntary parents of unwanted children."

Discussing possible effects of such liberalization on medical research and practice, he continues:

"Therapeutic abortion is grabbing at the easiest way instead of striving for the best way. When it is banned, medics have usually, under pressure of necessity, found a right way. Medical history justifies the belief that if therapeutic abortion is prohibited, the progress of medicine will remove the hazard therapeutic abortion was designed to avoid; but if it becomes the common practice, medical progress as to these conditions will enter a dead-end street. There will be no study or thought given as how to avoid harm from a normal delivery in any particular situation if there are never to be any normal deliveries in such a situation."

Artificial termination of pregnancies resulting from rape or incest is termed a danger for physicians since it could under certain circumstances make them liable for the commission of a crime, but discussion is reserved for the second installment, as representing a legal rather than a medical problem.

Difficulty of enforcement and other objections are recognized by the writer as valid considerations for not attempting legislation against them in the first place, but repeal of laws already enacted and generally accepted is another matter, he contends. In this connection he writes:

"We cannot shut our eyes to the fact that Americans today are looking more and more to Government to define right and wrong for them. When the common judgment of moral laws and the welfare of the social and political community have been embodied in penal statutes which have over the years proved their place in the popular consciousness . . . the moral judgment becomes identified with the statutes. In that situation repeal takes on the character of a vindication of the acts which had been previously condemned."

Mr. Eugene Quay is a graduate of St. Mary's College (Kan.) B.A., Georgetown University Law School, LL.B., and The Catholic University of America, M.A. (Constitutional Law.) He is now retired but for many years was active in practice in Chicago as a tax and corporate lawyer. During this time he was active in the American, Illinois State and Chicago Bar associations, serving on various committees and at one time as member of the board of governors of the ABA's insurance section and chairman of the federal court rules committee. He is an elected life member of the American Law Institute, [formed many years ago by Elihu Root, William H. Taft and others as a kind of legal academy] whose ex-officio membership includes members of the supreme court, law school deans and other jurists. It has largely concerned itself with efforts to gain more uniform laws (restatements of the law, etc.) and more recently with the drafting of Model Codes for submission to state legislatures. During 1956-57, Mr. Quay served as counsel to the American Bar Foundation's survey on criminal justice.

The scope of his current article is broad and, so far as can be determined, probably represents the most complete assembling of medical opinion and legal codes on abortion available. Whatever may be thought of the position taken, it is a scholarly and exhaustive review of the question which should merit the interest of physicians and lawyers alike.

Addenda

The new section of the new Criminal Code of Illinois pertaining to this subject matter, according to Walter L. Oblinger, general counsel, is as follows:

"Sec. 23-1 ABORTION. (a) A person commits abortion when he uses any instrument, medicine, drug or other substance whatever, with the intent to procure a miscarriage of any woman. It shall not be necessary in order to commit abortion that such woman be pregnant or, if pregnant, that a miscarriage be in fact accomplished. A person convicted of abortion shall be imprisoned in the penitentiary from one to 10 years.

(b) It shall be an affirmative defense to abortion that the abortion was performed by a physician licensed to practice medicine and surgery in all its branches and in a licensed hospital or other licensed medical facility because necessary for the preservation of the woman's life."

The reference is Chapter 38 Ill. Rev. Stats., 1961, sec. 23-1. The new act was signed July 28, 1961.



According to the ISMS Constitution . . .

SECTION 5. THE COUNCIL SHALL have authority to organize the physicians of two or more counties into societies, to be suitably designated, so as to distinguish them from district societies, and these societies when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.



Editorials

Chicago TB Rate High

The number of new active cases of TB increased, but the number of deaths declined last year in Chicago. These statistics are based on 1960 census figures, and the over-all picture in this area is still grim. The case rate of 79 per 100,000 population is more than twice as high as that of the entire country (31). The death rate of 11 is almost twice as high as the national figure of 6.

The distribution of the disease shows little change over the years. Eight out of 75 community areas had 100 or more active cases each. Forty-five per cent of the cases came from these eight areas. The largest number (398) came from the Near West Side, and 300 of these were moderately or far advanced when discovered. The same eight communities accounted for 44 per cent of all the TB deaths in Chicago. The incidence of tuberculosis usually is substantially higher in metropolitan than in rural areas. A downward trend was noticeable in suburban Cook County and for the county as a whole. Provisional figures for 1960 released by the U.S. Public Health Service show that the number of new active cases fell from 57,535 in 1959 to 55.623 in 1960. TB deaths declined from 11,474 to 10,670 during the same period.

Staph Infections in Hospital Nurseries

Staphylococci have caused epidemics and in some cases deaths in hospital nurseries in the United States and abroad. They are the chief cause of infection in maternity units. A careful search usually shows that 40 per cent of the newborn harbor these microorganisms on their bodics. Only a small percentage develop infections such as boils, breast abscess, pneumonia, and bacteremia.

A new technic was tried with considerable

success at the Palo Alto-Stamford nurseries and at the Grace-New Haven Community Hospital. All of the infants are washed immediately after bath with a 3 per cent solution containing hexachlorophane. Physicians and nurses wash their hands in the same solution before handling each child. Sterile precautions are customary procedures.

A bacteriological study of 777 Palo Alto infants treated in this manner was revealing. Only 10 had staphylococci on their bodies, or 1.3 per cent of the patients. None developed infections. Only 3.1 per cent of the 965 Yale infants carried the germ.

Antiseptic skin care of the newborn obviously pays off. But results of these separate studies are not surprising. Cleanliness has always paid off. There has been a tendency to be negligent along this line since the discovery of the sulfon-amides and the antibiotics. Cleanliness is a basic principle in the practice of surgery and obstetrics. It is a prophylactic measure that is hard to beat.

Industry Asks for Cost Reduction

Last April, R. Conrad Cooper of the United States Steel Corporation addressed the Scientific Academy of the American Academy of General Practice. From excerpts printed in Health Insurance Viewpoints we quote some cogent throughts that call for action on our part.

"Our second concern is that we find ourselves involved, perhaps unwittingly, certainly unwillingly, in the middle of a growing conflict regarding structure of the medical care system that exists in America today. Unhappily there are signs that some people wish to make collective bargaining a major area for the pursuit

(continued on page 65)



Number 27

Viral and Rickettsial Diseases

Disease	Test or Material Name	Source	Comment
Cat Scratch Disease	Foshay test	Dr. Lee Foshay University of Cincinnati Medical School or South Bend Medical Foundation, Inc. 531 North Main South Bend, Ind.	Correlation excellent
Lymphopathia (lymphogranuloma) Venereum	Frei test (Lygranum)	Squibb	Correlation excellent
Mumps	Enders test	Lederle Eli Lilly	If positive, patient had mumps. Fair correlation.
Smallpox	Cowpox virus	Many	Reaction of immunity indicates immunity. Primary vaccinia reaction indicates susceptibility and establishes immunity.
Bacterial Diseases			_
Chancroid	Ducrey test Ito-Reenstierna test	Lederle	Negative reaction rules out chancroid.
Diphtheria	Schick test	Wyeth, Cutter, National Drug	Excellent for finding susceptibles.
Brucellosis	Huddleson's test Brucellin Brucellergin	Merck Sharp & Dohme Merck Sharp & Dohme	Of limited value in diagnosis. May produce false rise in agglutination titres.
Scarlet Fever	Dick test	Wyeth	Of little use—results appli- cable to skin rash only, no other part of the disease.

Disease	Test or Material Name	Source	Comment
Tuberculosis	Vollmer (patch) Von Pirquet (scratch) Mantoux (Intradermal) Rosenthal Tine (prick)	Lederle (Old Tuberculin) Many (Old Tuberculin) Many (Old Tuberculin or PPD) Lederle (Old Tuberculin)	Mantoux the most sensitive, but all are excellent.
Tularemia	Foshay test	Lederle	Excellent correlation and becomes positive before serum agglutinins rise.
Fungus Diseases A. Superficial			
Candidiasis	Oidiomycin	Hollister-Stier	Of limited value
Epidermophytosis	Trichophytin	Hollister-Stier	Of limited value
B. Deep			
Blastomycosis	Blastomycin	Parke-Davis	Presumptive evidence if positive.
Coccidioidomycosis	Coccidioidin	Cutter	Good correlation
Histoplasmosis	Histoplasmin	Parke-Davis	Excellent correlation. In diagnostics should be done in a battery with Tuberculin, Blastomycin, and Coccidioidin.
Parasitic Diseases			
Echinococcosis	Casoni's test	Eli Lilly (Investigator use) NIH, Bethesda (1/10,000 cyst fluid)	Correlation good, but some cross reactions occur with other helminths.
Filiariasis		Eli Lilly (Investigator use)	Correlation fair, but cross reactions frequent.
Toxoplasmosis	Toxoplasmin	Eli Lilly (Investigator use)	Very specific test.
Trichinosis	Bachman test	Lederle	Mainly of negative value due to high percentage of positive reactors in U.S.



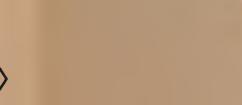


Diseases of Unknown Etiology

Disease	Test or Material Name	Source	Comment
Sarcoidosis	Nickerson-Kveim Reaction	Dr. Carl T. Nelson Department of Dermatology Columbia University New York, N.Y. or Dr. R. D. Judge University of Michigan Ann Arbor, Mich. or Department of Dermatology University of Wisconsin Madison, Wis.	Correlation fair, but requires biopsy of the test site and histologic examination.

Allergic Diseases

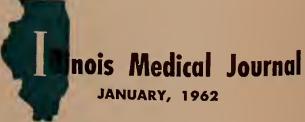
Antigen	Preferred Testing Method	Reliability of Positive and Negative Tests	Forms Available	Sources
Pollens (Trees, grasses, and weeds)	Scratch, followed by intradermal using a 100 fold reduction of the concentration that gave the negative scratch test.	Excellent	Powders* (scratch only) Fluidextracts (scratch and intradermal)	Abbott North Chicago, Ill. Allergy Labs, Inc. 1111 N. Lee Ave. Oklahoma City, Okla.
Molds Seasonal (Alternaria and Hormodendrum) Environmental (Aspergillus and Penicillium)	Scratch, followed by intradermal as above	Excellent	Powders and Fluidextracts	Barry Labs 9100 Kercheval Detroit 14, Mich. Center Labs Port Washington, N.Y.
Environmental inhalants (House, dust, feathers, danders, etc.)	Scratch, followed by intradermal as above	Good to fair	Powders and Fluidextracts	Hollister-Stier 127 N. Dearborn Chicago 2, Ill.
Violent foods (egg, nuts, seeds, fish, and shellfish)	Scratch only**	Good to fair	Powders and Fluidextracts	Luden 1050 Ponce de Leon Ave. Atlanta 83, Ga.
Weak foods (all others)	Scratch	Poor	Powders and Fluidextracts	Purex 346 Broadway Staten Island, N.Y



Antig⊕n	Preferred Testing Method	Reliability of Positive and Negative Tests	Forms Available	Sources
Stinging insects	Scratch	Good	Fluidextracts	Wyeth Philadelphia, h (Tubex)
Contact Dermatitis	3			
Plant oleoresins	Open patch	Good	(Acetone extract)	Hugh Graham Allergy Lab Box 12026 Dallas 25, Texa
Cosmetics	Open patch	Use material as is. Also small test kits available on request from		Borden, Marcelle Division 350 Madison Am New York 17, 117
				Texas Pharmaci P.O. Box 1659 San Antonio 6, Texas
Household and Industrial Contactants	Patch	of test concentration	nt's environment. Co ons such as the one Occupational Diseas hia, 1947.	available in Schwar

^{*}Fluidextracts are more potent than powders on initial preparation. On the other hand, powders maintain their potency longer. Therefore, frequent tests make fluidextracts more desirable while infrequent tests make powders more desirable.

from the



^{*}Deaths have occurred during intradermal tests with this group, and constitutional reactions on scratch testing are not unknown.

[†]Condensed by Dr. R. F. Beers, Jr. from his chart that will appear in Skin Tests and Disease by E. E. Vicher and R. F. Beers, to be published by Charles C Thomas, Springfield, Illinois.

Editorials (continued from page 60)

of this conflict. This is especially regrettable because we believe that if restructuring of the system is needed, and is soundly to come about, the way must be led by the medical care practitioners, and not by labor unions, industry, government, or anyone else.

"Our third concern about medical care runs to its costs which are steadily and steeply rising with no end yet in sight. In my own company insured medical care costs, including cost of sickness and accident benefits, amounted to about 40 million dollars in 1960."

From industry's point of view he made the following comments:

"As businessmen, we know of no way to meet our competitive challenges except to improve the efficiencies of our operations, reduce the costs of production, and increase the quality and quantity of our products and services.

"We believe that . . . the medical profession likewise faces a major and comparable competitive challenge. It has been said that the rise in costs will continue until the only one able to pay for it will be Uncle Sam, and then we will have socialized medicine. If costs continue to rise without end, this could happen. We in industry do not want socialized medicine, any more then we want socialized industry.

"We believe that an approach to the control of costs should first be the responsibility of the physicians who are the core of the system and know it intimately."

There is no doubt that costs are going up. We have no objection to rising costs due to medical advances. We cannot control those due to the increase in capital and operating expense. But the physician can control the cost by using good judgment on who is hospitalized and how long the individual should remain on sickness disability. This is one of our major problems with industry today.

Balance Sheet on Health Bills

In one of the final acts of this year's session, the Congress voted a massive \$738 million in new money for the National Institutes of Health. It was part of an appropriation bill that earmarked a total of \$1.2 billion for the

Public Health Service and \$4.2 billion for the Department of Health, Education, and Welfare as a whole.

NEW HEW HEALTH APPROPRIATIONS (1962 versus 1961 in millions of dollars)

(1002 versus 1001 in immons	or donar	3 /
Departments	Fiscal 1962	Fiscal 1961
Public Health Service Total	\$1240.	\$976.9
Chronic diseases and health of the aged Communicable disease activities	3.9 10.	1.4 9.9
Community health practice and research Control of tuberculosis Control of venereal diseases	24. 6.5 6.	23.4 6.5 6.
Hospital construction activities Air pollution control Occupational health	203. 9. 4.	188. 7. 3.3
Radiological health	11.	8.
National Institutes of Health:		
General research and services National Cancer Institute Mental health activities National Heart Institute National Institute of Dental Research Arthritis and metabolic disease	128. 143. 109. 133.	77. 111. 101. 86.2
activities Allergy and infectious disease activities Neurology and blindness activitie	82. 56.1 es 71.	61. 43.1 56.4
Subtotal, National Institutes of Health	738.3	548.2
Grants for construction of cancer research facilities Grants for construction of hospital	5.	5.
research facilities Grants for construction of health	10.	
research facilities	30.	30.
Food and Drug Administration	24.7	18.9
Office of Vocational Rehabilitation	88.4	74.5

Reprinted from Balance Sheet on Health Bills. Medical World News, page 30. Oct. 13, 1961.

The Rugged Individualist

Here's a true and documented story we hope our readers will appreciate.

The story is about a young man who formerly lived with his parents — in a public housing unit. He attended public schools and was nourished every noon via the school's "free lunch program." He then went into the Army and kept his GI life insurance — which annually refunds almost the total premium cost.

After he left the Army, he enrolled in a state university and worked at the state capitol to supplement his GI education checks. Soon after he graduated, he married a public health nurse and bought a home with a GI loan. He then obtained a Reconstruction Finance Corporation loan and went into business on his own.

Their baby was born in the city hospital and a few months later, our hero bought a ranch—with assistance from the veterans' land program. He obtained emergency feed from the government. Later he put the ranch in the soil bank and used the payments to clear the mortgage. Then the government paid 70 cents for every 30 he paid to put the "soil bank" land in grass.

Our friend's parents live with him on the ranch and collect Social Security checks. The Rural Electrification Administration has supplied electricity; the government helped him clear his land; the county agent showed him how to terrace it; and the government built him a fish pond.

About a month ago, he wrote his Congressman the following letter:

"Dear Sir: I wish to protest these excessive governmental expenditure and attendant high taxes. I believe in rugged individualism. I think people should stand on their own feet without expecting a handout. I am opposed to all socialistic trends, and I demand a return to the principles of our Constitution and the policies of States' Rights."

We always admire a rugged individualist!

Reprinted from the July 1961 issue of GP, published monthly by the American Academy of General Practice,

Correspondence -

December 15, 1961

Dear Dr. Van Dellen:

Let's keep the Illinois Department of Public Health *Out* of Private Medicine.

Under the guise of blessings by the A.M.A. and the I.S.M.S., the Illinois Department of Public Health has launched¹ "an aggressive coordinated plan to achieve complete local health department coverage" in all 72 downstate counties (at present without such a department),

regardless of whether the local people want it or need it. This is plain old fashioned empire building by a branch of government medicine. At best this is a waste of tax money, and at its worse, another nibble out of the diminishing business called "the private practice of medicine." The Achille's heel of this ambitious program is the embarrassing question "what would a public health nurse do that your own office aid is not already doing better" or "what would a public health doctor do in your county that you are not already doing."

I have just finished reading "Private Medicine and Public Health" by Dr. Franklin D. Yoder, Director, Illinois Department of Public Health. The article is found on page 302 of the November Issue of the Illinois Medical Journal. The article is sincere, honest and obviously the work of a dedicated man. However, it may be worthwhile to analyze the implications of the plan to "embark upon an aggressive, co-ordinated plan to achieve complete local health department coverage for the citizens of our state." Dr. Yoder's definition of "Public" in public health is "and please remember that by 'Public' I mean over 10 million people in Illinois. Public health is people."

What this amounts to is an attempt to drum up grass roots support for an extension of the Illinois Public health service into every county in Illinois. Whether or not the people want it or need it.

I am proud of the accomplishments of the Illinois Public Health Service. The record of venereal disease and tuberculosis control speaks for itself. The provisions of vaccines and antigens has facilitated control of other communicable diseases. Maintenance of laboratories for the diagnosis of everything from rabies to excess nitrites in well water has contributed to the health and welfare of the people. Inspection of municipal water supplies and restaurants has reduced epidemics due to unsanitary procedures. Radiation detection survey teams offer valuable suggestions for the protection of our x-ray technicians. Inspection of

^{1.} Private Medicine and Public Health, Dr. Franklin Yoder, Springfield; Director, Illinois Department of Public Health, Luncheon Address at Annual Secretaries Conference in Springfield, October 8, 1961, Illinois Medical Journal 120:302-309.

hospitals and nursing homes has done much to raise and maintain standards in these institutions. Poison control and premature infant centers are invaluable additions to private medical facilities. There are many other valuable services provided by our Public Health department for which I am grateful and thankful. There are new fields to conquer.

I am also proud of the accomplishments of the members of the Wayne County Medical Society, past and present. Over 95 per cent of all our children have been immunized against polio, whooping cough, tetanus and diphtheria. Each member donates some of his time to public health programs such as the American Cancer Society, American Heart Association, and Retarded Children, etc. When the vote came up to make a permanent levy for the Wayne County Sanitorium Board, the Medical Society supported it publicly. We give our time to the American Red Cross Blood procurement program, Civil Defense, and hospital disaster planning. We support the Washington University Eye Bank through the local Lion's Club, and hospital and by signing away our own eyes. We work in close cooperation with the crippled children's clinics, the TB sanitarium in Mt. Vernon and our local public health nurse, Veda Hawkins.

We give instruction in "First Aid" to laymen and publish a weekly article in the Wayne County Press called "Rx for More Healthful Living" (a Column of Health Hints from Your Wayne County Medical Society). We support fluoridation of the public water supply and use seat belts in our personal cars to promote their acceptance. There are many other valuable services provided by the members of our medical society of which I am very proud. There are new avenues to explore such as expanding our present pap-smear and tonometry exams, establishing a progressive care program in our local hospital to include a rehabilitation and physiotherapy wing and a nursing home, introducing preventive psychiatry into the mental hygiene curriculum of the grade school, encouraging employment beyond age 65 where practicable, placing diagnostic examinations back in the physician's office and recruitment of the local "cream of the crop" for medical careers.

Now to quote Dr. Yoder: "any effective health service must be geared to the needs of the people. We have to use your knowledge to determine local health needs." Now I say that the (medical) needs of the people in Wayne County can best be determined not by the Illinois Department of Public Health in Springfield or by a public health officer in Jefferson County, nor by a public health nurse in private practice in Wayne County; and furthermore it is my contention that we can best serve our own people by providing them with the best care that medicine has to offer, the skill and judgment of their private family physician.

It is my considered opinion that the majority of people in Wayne County neither need nor want a local public health department, and I give Dr. Yoder credit for complete honesty when he says he needs our help: "The medical society should be in the forefront of any local movement to establish county health departments."

Last year Dr. Fatherree (at the time Director, Illinois Department of Public Health) came down to Mt. Vernon to enlist the support of the Hamilton-Jefferson and Wayne County Medical Societies in a "drive" to establish a three county health department. I asked him to suggest what, if anything, such a department would do that wasn't already being done by private medicine. I also requested written material outlining the services provided by such local health departments. To date, I have received neither a satisfactory answer, nor written information concerning the program I was asked to support. It is becoming obvious to me that this program is being pushed "from the top." Last month the local Home Advisor, Jean Wison, called me and asked what the program was about as she was being enlisted in the promotional effort. This is worse than a "pig in a poke;" it looks to me like a doctor in a Trojan Horse.

Two recent events indicate the characteristics of the above mentioned horse.

- 1. Castro admitted publicly that he is a Marxist-Leninist Communist.
- 2. The American Public Health Association's governing council adopted a resolution in Detroit backing Social Security care of the aged (King-Anderson).

Arthur R. Marks, M.D., President Charles J. Jannings, M.D., Secretary Wayne County Medical Society



CLINICAL SPIRITS

Dr. William Dock, formerly professor of medicine at Stanford University and now professor of medicine at the State University of New York, reported the actual clinical uses of a variety of alcoholic beverages in the treatment of specific diseases. He related the value of many old medicinal tonics to the sherry or other beverages being used as the solvent, presented new evidence on the value of small amounts of whiskey, brandy, and similar distilled spirits in the control of emotional anxiety, and disclosed recent applications of wine in the treatment of diabetics and surgical patients. In particular, he emphasized the strategic value of alcohol as a normal component of a diet to be prescribed by physicians and even to be used by physicians themselves.

PHARMACEUTICALS

Drolban (dromostanolone) is Lilly's new synthetic steroid for the treatment of advanced carcinoma of the breast. The product is related somewhat to testosterone but with less virilizing effect. A series of 140 patients with advanced cancer of the breast were treated.

Objective remission was noted in 10 of the 47 premenopausal women and in 23 of 93 postmenopausal women. It is as effective as testosterone but has almost no masculinizing effect. Mild virilism, acne, facial hair growth, and enlargement of the clitoris occurred in some patients.

The recommended dosage is 100 mg. intramuscularly three times a week for so long as satisfactory results are obtained. Treatment should continue for at least 8 to 12 weeks before any conclusions are drawn as to the efficacy of this steroid. Gantanol is Roche's new sulfonamide. Prior to marketing, it has been used to treat bacterial infections in over 5,000 patients. A satisfactory response occurred in over 89 per cent with respiratory infections, 71 per cent with urinary tract infections, both chronic and acute, and 86 per cent of those with miscellaneous infections.

A promising new injectable antibiotic was announced recently by the Upjohn Company. It is known as actinospectacin and was most valuable in urinary tract infections.

Glucagon is the "new" hormone that provides prompt relief to diabetics in severe insulin shock. It is not a new product, having been identified in 1923 by Dr. John R. Murlin.

GOUTY SYMPTOMS

An inflammatory reaction was produced in gout patients when a sodium urate crystal was injected into the joint. Volunteers complained of pain, tenderness, swelling, and redness. The response, according to investigators at the National Institute of Arthritis and Metabolic Diseases, was similar to that found in acute gouty arthritis. This my explain why a recurrence of gouty symptoms is not always related to the uric acid level of the blood.

MEDICAL EDUCATION'S FUTURE

According to the Association of American Medical Colleges, the number of students accepted for enrollment in U.S. medical schools in 1960-61 increased the total by 48 over last year. This is the sixth consecutive yearly increase, and in this instance we can thank the new University of Kentucky College of Medicine.

The total accepted applicants for the 1960-61 group was 8,650. Last year it was 8,512 and the year before 8,366. In 1950-51 the figure was 7,254.

The future holds promise in that plans for five medical schools are in the offing. The five universities are Brown, Rutgers, Connecticut, New Mexico, and Texas. The possibilities of developing new schools in Arizona, California, Idaho, Illinois, Maine, Massachusetts, Michigan, Minnesota, New York, and Ohio also look favorable.

SUNBEAMS FOR THE VETS

The Sunbeam Corporation is turning over to the Hines Veterans Administration Hospital upwards of 40,000 traded-in electric shavers, and supplying, free of charge, the new combs and blades necessary for complete renovation. This is part of a patient therapy program for paraplegics, the mentally ill, and other disabled veterans. The company also has trained Hines therapists in the know-how of rebuilding the intricate mechanisms. The VA Supply Depot in Chicago will stock surplus razors for free distribution among patients in all of their 171 hospitals.

WHAT'S NEW

An electric prosthetic elbow is now under development at Northwestern. The source of power is a 12 volt battery containing rechargeable nickel cadmium cells. Several miniature mercury switches are arranged in the elbow unit in such a way that when the stump and attached socket are flexed forward the elbow is flexed, and when the stump is extended backward the elbow will extend. The elbow automatically remains locked in position between these two limits of flexion and extension. A prototype is nearly completed and will be amputee-tested shortly.

Gulton Industries, Inc. is manufacturing a mobile 9-gallon medical ultrasonic cleaner specifically designed for cleaning medical and surgical tools. It is constructed of stainless steel and weighs 340 pounds. Cleaning is accomplished by the action of ultrasonic energy produced by powerful transducers.



The new Velket tourniquet combines pure gum rubber and a super Velcro fastener. It is manually adjustable to any tension desired, and its new firm grip — the report says — may well make all other tourniquets obsolete.

Flint-Eaton and Company introduced a newly designed disposable enema unit that features 18 inches of flexible tubing for convenient administration. It is called TRAVAD and consists of a plastic bag containing 4½ fluid ounces of solution, with part of the bag shaped to serve as a pocket for the pre-lubricated rectal tip. The latter has a plastic guard to prevent too deep an insertion. The 135 cc. of solution contains 12 Gm. of sodium citrate.

A simplified, low cost testing kit aimed at helping make the individual doctor's office a cancer detection center has been introduced by the Gelman Instrument Company. Consisting of a polypore membrane filter and disposable plastic filter holder, it can be used at bedside or in the office to filter cancer cells from body fluids for laboratory examination. The physician squeezes a sample of body fluid through the filter from a common hypodermic syringe, caps the plastic holder and then sends or mails it to a pathology laboratory for staining and microscopic examination.

The kit is designed primarily as a diagnostic aid for detecting cancer in the cervix, uterus, bladder or other parts of the genitourinary system. It can be adapted to detection of cancer cells in the sputum, feces, blood, and peritonital fluids. Effectiveness of the membrane filters has been scientifically documented.

Meanwhile, Winthrop Laboratories is pushing their Lavema Compound Disposable Enema Kit. It was reported to have good or excellent cleansing of the descending colon in 70 of 77 patients in Tacoma, Wash.

YOUR PERSONAL SITZ BATH

A new portable sitz bath offers perineal, rectal, and genital soaking, plus whirlpool therapy. Reg-u-Temp Sitz Bath is manufactured by Harlan M. Buck, Inc. It can be used on a toilet



bowl with a nearby faucet. The contour seat is anatomically designed to allow maximum immersion of perineal areas while taking the patient's weight off the affected area. An improved design of the three position valve along with additional overflow vents permits more rapid filling and draining than previous models.

MONITORING PSYCHIATRIC PATIENTS

Closed circuit television is used now on the psychiatric wards of the Veterans Administration Hospital in Oklahoma City. Participation of patients was optional, but none refused. They were told that doctors and nurses might be watching the sessions on other TV screens. "Although at first, the TV camera seems to inhibit some patients in discussing their problems, some were hams from the start, and others soon became accustomed to it," Dr. Jay

T. Shurley, chief of psychiatry, reported.

The sessions were limited to selected hospital personnel who were expected to be able to profit from the results to improve treatment.

REQUIRED READING

During December the pharmaceutical companies stamped most of their envelopes with "Read Page 69 in the December Reader's Digest." The article blasts Kefauver and is subtitled: "How a Senatorial investigation loaded with politics and sensationalism threatens the growth and usefulness of an industry that has conferred an unmatched boon on humanity." It might be a good idea for physicians to read—and tell their patients about it.

SUMMING UP THE SALK INFLUENCE

The National Foundation reports that polio in the United States has declined by more than 90 per cent since the advent of Salk vaccine in 1955. The four-year average from 1950 to 1954 of about 38,000 cases fell to 3,190 in 1960.

Figures issued by the Health Insurance Institute substantially support this. The institute indicates that the 1960 polio figures are the lowest since the initiation of the Salk programs and are only 5.5 per cent of the 1952 high of 58,000 cases. In the first nine months of 1961 there was a decrease of 60 per cent (915 cases) from the first three-quarters of last year (2,290).

OB-GYN PUBLICATIONS

"What Is A Gynecologist" is the first such booklet prepared by the American College of Obstetricians and Gynecologists in a new public relations program launched this past year.

A first printing of 10,000 copies was distributed to physicians who are Fellows of the College. Bulk supplies of the booklet were offered to each physician on a self-liquidating cost basis.

Within six weeks — before the second printing of 150,000 copies had left the bindery — all of this supply had been sold out. Further orders require a third printing.

A second booklet for professional distribution regarding services and functions of the college is now being prepared.

FURALTADONE WITHDRAWN

Altafur (furaltadone) was withdrawn recently from the market by Eaton Laboratories. This action was taken when an examiner for FDA came to the conclusion that the efficacy of the compound was not sufficient to warrant further use in view of possible side effects.

AGE CALLS FOR B₁

Older women need more vitamin B_1 , says Dr. Helen C. Oldham of the Human Nutrition Research Division of the U.S. Department of Agriculture. She came to this conclusion after conducting experiments on 10 older and 8 younger women. Both groups of women were kept on similar diets for periods of one and a half to two months. Both groups consumed the same diets, but the older women excreted less vitamin B_1 than the younger. When diets deficient in vitamin B_1 were given to both groups, the older women showed the effects more rapidly. When the missing vitamin was replaced, the younger women recovered more rapidly.

PROFESSIONAL LIABILITY INSURANCE

The National Bureau of Casualty Underwriters recently revised professional liability insurance policies for physicians, surgeons, dentists, and hospitals. Many liberalizations and rate revisions were made. A physician or dentist is now covered by insurance if sued because of a decision made while serving on an accreditation committee of a hospital or medical society. In other changes, exclusions pertaining to injury caused while under the influence of intoxicants or narcotics were defined. This is intended to clarify coverage in areas where there may be some doubt as to their application, such as when the insured had a social drink or had taken a sedative in order to sleep.

QUICKIES AND QUACKIES

The pedestrian finally is getting a break. According to the Statistical Bulletin, the number killed in motor vehicle accidents decreased from 5.9 to 4.4 per 100,000, a reduction of more than 25 per cent in ten years.

The FDA made it official: "Honey is not a cure for premature death nor is it good for waning virility, rheumatism, arthritis, or a weak heart." So said the FDA when they seized nearly 3,000 pounds of honey at a Detroit health food store.

They also seized 43 copies of "Eat, Live and Be Merry" by Carlton Fredericks of Illinois. This was based on the Federal law prohibiting fake labeling of foods and drugs. Fredericks has a daily radio program on nutrition and other subjects that is carried by many stations. He is listed on the front cover of his book as "America's Foremost Nutritionist." The latter was challenged by the FDA as being false and misleading because he has had no formal training as a nutritionist. He has a Ph.D. in the field of health education and recreation. The seizure proceedings charge that the Fredericks book contains statements that suggest that he furnishes scientifically proven nutritional and medical guidance for the supplemental use of vitamins and minerals by individuals generally in the treatment and prevention of serious disease, which statements are false and misleading since they are contrary to fact.

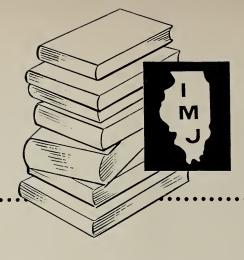
There were 18 reported cases of tularemia in Illinois by the middle of October, according to the state Department of Public Health.

That Sterling Drug, Inc. is persistent. On November 6 they sent a two-page news release entitled "Aspirin preferred in treating rheumatic fever." On November 8 we received another release entitled "Aspirin recommended to treat Spondylitis."

The ACS tells us again that quitting cigarette smoking appreciably reduces the risk of lung cancer and eliminates from the bronchial lining abnormal cells that tend to become malignant. It is high time we put this in our pipe and smoke it.

HEW as of November 24 said that radioactive iodine levels in air, water, milk, and other foods were not high enough anywhere in the country to justify general use of nonradioactive compounds to block the uptake of radioactive iodine by the thyroid gland.

Book Reviews



Surgery: Principles and Practice. Edited by Henry N. Harkins, M.D., Jonathan E. Rhoads, M.D., and J. Garrott Allen, M.D. \$17. Pp. 1,595. Philadelphia, J. B. Lippincott Company, 1961.

A second edition of this well known and respected text will be welcomed by students and physicians who are familiar with the 1957 volume and who have felt that its excellence has been marred in recent years by necessary omission of recent surgical advances. Updating of most chapters and addition of a section on surgical history has strengthened and lengthened the current offering. Indeed, the only valid criticism which can be leveled is that this tome weighs nearly seven pounds and is a discomfort to hold and read. This unimportant physical fact aside, the text remains a magnificient contribution to teaching of surgery.

Editorial responsibility has been rotated in this edition in an effort to prevent the volume from becoming known by a single author's name. The three editors have again written approximately one-half of the text. The remainder is added by a remarkably widespread group of surgeons.

In all, thirty-four contributors are the chapter authors. Most are familiar names in surgical literature; many almost synonymous with their field of surgery or research. Oliver Cope, for example, long associated with study of diseases of the parathyroid glands, summarizes current knowledge regarding these disorders and includes much subject material from recent publications.

A bibliographic index is a new feature of this edition. While this is of value, the student may be surprised at the paucity of references dated after 1955. Exceptions are found in the chapters

on peripheral vascular and cardiac conditions.

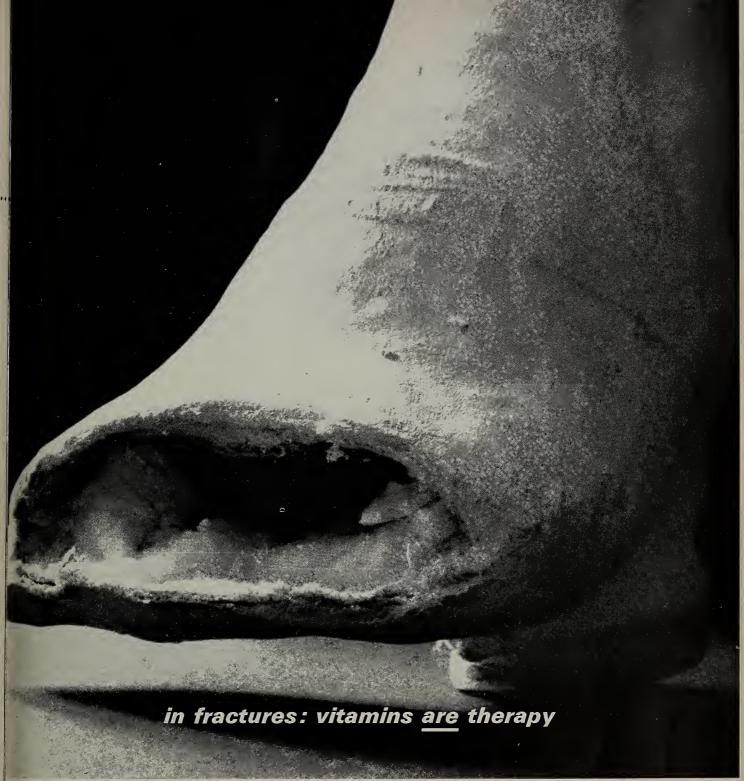
Illinois surgeons have written an extensive portion of this text. J. Garott Allen, recently of the University of Chicago, is the author of seven chapters and a contributor to an eighth. The breadth of his experience and the background material that he brings to his sections is fascinating. A lucid chapter on pulmonary tuberculosis is the work of William Adams, chairman of the department of surgery at the University of Chicago. Surgical peripheral vascular disorders are well explicated by Drs. Julian and Dye of the University of Illinois. Their basic descriptions of pathologic processes are matched by the excellence of the diagrams which illuminate this chapter. A timely contribution by Paul Harper of the University of Chicago explains the use of radioisotopes in surgery. Also, Dwight Ingle, chairman of the department of physiology at the University of Chicago, has presented an interesting section on pituitary and adrenal function in health and disease.

This volume is highly recommended to physicians, surgeons, and students who wish to bring their surgical libraries up to date.

John J. Bergan, M.D.

THORACIC DISEASES EMPHASIZING CARDIOPUL-MONARY RELATIONSHIPS. Eli H. Rubin, M.D., and Morris Rubin, M.D. \$25. Pp. 968. Philadelphia, W. B. Saunders Company, 1961.

This book is comprehensive in scope. It covers the field of thoracic diseases as generally categorized, emphasizing the "medical" aspects rather than the "surgical" and by the same token highlights in them their physiologic implications. It is as the senior author states in



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

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Vitamin B ₂ (Riboflavin)	10 mg.
Niacinamide	100 mg.
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Vitamin B ₆ (Pyridoxine HCI)	2 mg.
Vitamin B ₁₂ Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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the preface, an attempt "to orient the student in current developments in thoracic diseases."

Surgical treatment is nonetheless discussed even to the inclusion of some technical details in the more standardized operations such as pneumonectomy, pulmonary lobectomy, and lung biopsy.

The organization of all this material is interesting, and in general progresses in orderly fashion from the basic anatomy and physiology on to the various anomalies and disease processes grouped by regions or other common bonds.

Among the more unusual of such headings, one finds "Thoracic Diseases in the Young," "Bronchial Obstructive Diseases," and "Thoracic Manifestations of Systemic Diseases." (This latter section reflects a previous book by one of the present authors.) A final section on "Principles of Diagnosis" takes up the patient, his story, and his examination.

There are 968 pages in all, divided into 53 chapters. The book is beautifully produced, featuring clear, easily readable print and profuse, lucid illustrations. A selected but ample set of bibliographic references follows each chapter. The index is very adequate, occuping 29 pages.

No single book covering so large a field can be truly exhaustive. This one, however, does serve well as a source of collected opinions. Most often these opinions are very well digested for prompt assimilation by a reader in search of concise authorative views. On the other hand, they rarely sacrifice the spice of controversy when such exists.

If criticism can be levelled at this volume, it would be that this penchant for completeness, however desirable, can leave the unseasoned reader to sort information for himself and can force him to arrive at his own conclusions essentially unguided. This effect would appear very likely when older views or therapeutic maneuvers are discussed at such length that their value, principally as historical background material, is lost from view. Greater clarity in distinguishing these various categories of data would appear to be desirable.

The authors are certainly to be congratulated on the completion of what must have been a gigantic undertaking, and this book should long serve as a source of collected opinions to date in the manner of a milestone.

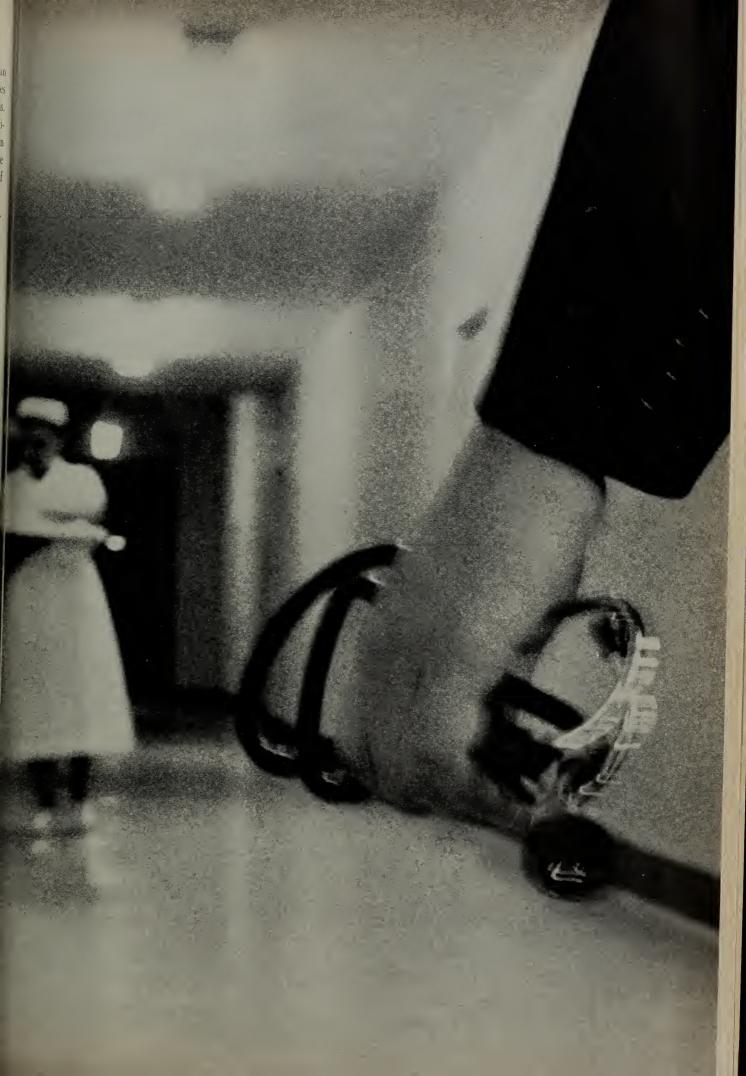
Hiram T. Langston, M.D.

Don't Forget!

If you want your committee reports or resolutions in the April issue of IMJ, copy is due Feb. 15.

ANNUAL MEETING DATE: MAY 13-17, 1962





NEWS of the STATE



Champaign County

The Champaign County Medical Society elected its 1962 slate of officers at the November meeting. They are Drs. J. C. T. Rogers, president; E. C. Albers, president elect; and H. E. Wachter, secretary-treasurer, all of Champaign.

Delegates are Drs. W. H. Schowengerdt, Champaign, and J. E. Walton, Homer, both for two-year terms. Drs. H. M. Buley, Champaign, and M. Koeck, III, Stickney, are alternates.

Cook County

Building Fund Gift to N.U.

Northwestern University Medical School has received \$500,000 from J. H. Elder, Midland, Texas, for construction of its new medical library.

The library will cover the entire first floor of the planned \$7.5 million, 15-story addition to the Montgomery Ward Memorial Building. The addition will connect with the Ward Memorial and Morton Medical Research buildings on seven of its floors.

To be included are an exhibition gallery and rare book room containing more than 10,000 rare medical volumes and illustrations valued at over a quarter of a million dollars. The new library will double the stack area, study facilities, and library work areas, and provide a new browsing room and audio-visual aid facilities. It will expand the total research and educational plant of the school by 50 per cent.

In 1957 Mr. Elder gave \$500,000 to the university for construction of a men's dormitory, Elder Hall, in Evanston.

Dr. Fishbein New CMS President

Dr. Morris Fishbein, Chicago, was elected president of the Chicago Medical Society at a meeting of the society's Council in December. He fills the unexpired term of Dr. Patrick H. McNulty, who died last November 3. Dr. McNulty became president of the society in June.

Dr. Van Dellen Heads Heart Fund Drive

Dr. T. R. Van Dellen, editor and medical educator, has been appointed general campaign cochairman of the 1962 Chicago Heart Fund Campaign.

The editor of the *Illinois Medical Journal*, Dr. Van Dellen is also assistant dean of Northwestern University Medical School, medical director for the Chicago Tribune, and medical editor for the Chicago Tribune-New York News Syndicate.

In his capacity as co-chairman, Dr. Van Dellen will be part of the team directing the campaign for \$1,350,000, which will go to further the association's research, education, and service programs.

In addition to being a member of the board of governors of the Chicago Heart Association, Dr. Van Dellen is immediate past president of the American Medical Writers' Association. He has received numerous citations and awards, among them the Citation of Merit from the Illinois Public Aid Commission and the Distinguished Service Award from the American Medical Writers' Association.

Kane County

The following officers of the Kane County Medical Society were elected for the coming year at the October meeting: Dr. William J. Ball, Aurora, president; Dr. J. L. Bordenave, Geneva, vice president, and Dr. Carl M. Kester, West Dundee, secretary-treasurer.

Madison County

Dr. Eugene Moore, Collinsville, was honored



with an engraved plaque from the Madison County Medical Society at the annual meeting dinner in November. As guest of honor he also received a citation for devoted service during the 21 years he had been secretary and editor of the county bulletin.

Dr. Moore most often worked out of his home during his tenure from 1939 to 1960; membership rose from 105 to 130 in this span. In the hectic era of World War II and the postwar period his stabilizing influence helped keep the society in equilibrium.

McLeon County

The McLeon County Medical Society has established a Committee on Aerospace Medicine to increase interest and focus attention on matters concerning aerospace medicine, general aviation medicine, and aviation safety in central Illinois.

Dr. George B. McNeely, Bloomington, head of the aircraft investigation team for the Federal Aviation Agency in his area, is the committee chairman. Dr. McNeely was appointed an aviation medical examiner in 1946 and has been active in the field since 1942.

Whiteside County

Dr. Ralph Dolkart, Chicago, will address the



RO-CILLIN (phenethicillin potassium)—the preferred form of oral penicillin—is indicated whenever oral penicillin is called for.

Advantages: (1) higher blood levels, (2) effective in certain "G-resistant" infections, (3) dependable action—no known non-absorbers.

Ro-Cillin Oral Solution with its NEW, UNSUR-PASSED FLAVOR is the pediatric penicillin of choice.

Available as: 250 mg. tablets and 125 mg/5cc oral solution.

Side effects and precautions are the same as for penicillin G. Use with care where there is a history of allergy, especially to penicillin.

COLREX COMPOUND

provides broad-spectrum symptomatic relief of the common cold and other acute respiratory conditions, utilizing the well known synergistic effect of codeine and papaverine. Each yellow capsule (Rx only) contains:

Antitussive-analgesic: 16 mg. codeine phosphate, 16 mg. papaverine hydrochloride and 300 mg. aluminum aspirin.

Decongestant: 5 mg. phenylephrine hydrochloride Antihistaminic: 2 mg. chlorpheniramine maleate Plus 100 mg. Vitamin C to promote added resistance to infection.

Colrex Compound is rarely contraindicated—only in post-addicts to codeine and those with allergic reactions to opium alkaloids. Side effects, seldom encountered, include drowsiness, constipation and gastric distress.

For additional information, see your local Rowell man, or write:



for January, 1962 93

longer-acting, fewer injections for fetal salvage with no androgenic effect

Squibb Hydroxyprogesterone Caproate

Long-acting Progestational Therapy

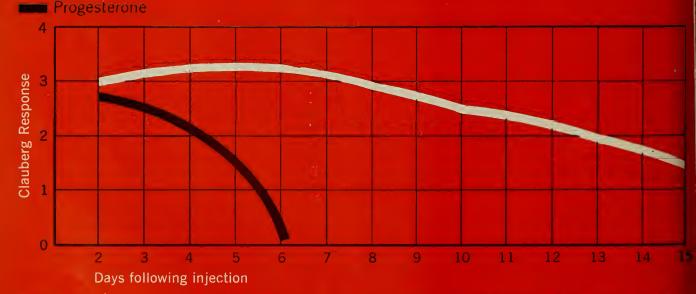
Delalutin offers these advantages over other progestational agents: Significantly improved rate of fetal salvage¹⁻³ No virilizing effect on female fetus or mother High, sustained hormonal level in the uterine muscle and mucosa⁴— high enough even to replace an excised corpus luteum⁵

Absence of local tissue reactions³.

Comparative effect of single subcutaneous injection of Delalutin and progesterone on the progestational changes (Clauberg Test) in the rabbit uterus.

Borman, A.: Laboratory Report on the Duration of Action of 17-Alpha-Hydroxy-progesterone-n-Caproate (Delalutin). The Squibb Institute for Medical Research, May 17, 1955.

Hydroxyprogesterone Caproate (Delalutin)



Supply: Vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil with 35% benzyl benzoate. Vial 5 cc., each cc. containing 250 mg. of hydroxyprogesterone caproate in castor oil with 61% benzyl benzoate. References: 1. Boschann, H. W. Ann. New York Acad. Sc. 71:727 (July 30) 1958. 2. Reifenstein, E. C., Jr.: Ann. New York Acad. Sc. 71:762 (July 30) 1958. 3. Castelazo Ayala, t. et al.: Gin. y Obstet. de Mexico 14:249 (May-June) 1959. 4. Plotz, E. J.: Abortion (Hemorrhage of Early Pregnancy), in Conn, H. F.: Curratherapy – 1960, Philadelphia: W. B. Saunders Co., 1960, pp. 613 ff. 5. Wright, H. L., Withers, R. W., and Ingram, J. M.: Am. Pract. & Diameter. 10:1544 (Sept.) 1959.

Complete Information on administration and dosage is supplied in the package Insert and In your Squibb Product Reference and Product Brief





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Deliut non a equibb to deliver

Whiteside County Medical Society on February 22 in Gordon's Lounge, Sterling. His talk on diabetes was arranged by the Committee on Postgraduate Medical Education and Scientific Service.

Winnebago County

Mr. Floyd E. Tarbert has resigned as executive secretary of the Winnebago County Medical Society. He had held the position since 1954 when he became the first full-time executive secretary of a county medical society in Illinois. He was also managing editor of the Bulletin.

General

New Retired and Emeritus ISMS Members

Emeritus membership in the Illinois State Medical Society was approved for the following physicians at the November 19 Council meeting: Morris Fishbein, Earl D. Huntington, Laurence H. Mayers, Harry C. Rolnick, and Arthur W. Woods, all of Chicago; D. Hobart Ecke and Mark Greer, Vandalia; John A. Gardiner, La Grange; and Alice K. Hall, Oak Park.

Elected to retired membership were the following: Arthur C. Conrad, Clifford L. Dougherty, Louis E. Halperin, Clarence C. Saelhof, Heyworth N. Sanford, Carl C. Shipley, and Ernest B. Zeisler, all of Chicago; Walter A. Bayard, Park Ridge; Everett C. Kelly, Peoria; Adolph C. Midthun, Oak Park; and Harry B. Rubin, Oak Lawn.

Elections

Dr. Walter Palmer was elected president of the University of Chicago Cancer Research Foundation in December.

Dr. Palmer, an authority on gastro-intestinal cancer, recently became the Richard T. Crane Professor emeritus, department of medicine.

Medical Alumni of Michael Reese Hospital and Medical Center have elected Dr. Louis D. Boshes, Chicago, as president for the 1961-62 term; Dr. Sylvan L. Weinberg, Dayton, vice president; and Dr. Bernard J. Weinberg, Chicago, secretary-treasurer.

(continued on page 97)

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note: Should be given with caution in glaucoma.

dosage: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. Atarax) 3 to 4 times daily. When indicated, this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. Atarax). For convenience, write "CARTRAX 10" or "CARTRAX 20." Supplied in bottles of 100. Prescription only.

1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

*brand of hydroxyzine **pentaerythritol tetranitrate



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Continuing in their respective offices with the American Academy of Dermatology for 1962 are Dr. Stanley E. Huff, Northwestern University, Evanston, assistant secretary-treasurer; and Dr. Samuel J. Zakon, also at Northwestern (Chicago), historian.

Appointments

The University of Illinois College of Medicine has recently appointed the following Chicago physicians to its faculty: Bernard L. Greene, clinical assistant professor of psychiatry, and Kate H. Kohn, clinical assistant professor of physical medicine and rehabilitation.

Col. Frederick Plotke, M.D., MC, USAR, on military leave of absence from his position as chief of Public Health Service in the Illinois Department of Mental Health, has been assigned to Walter Reed Army Institute of Research, Washington, D.C.

Awards

Dr. Stephen Reid, Evanston, has been named

to the Sports Illustrated Silver Anniversary All-America for 1961. Dr. Reid was nominated by his alma mater, Northwestern University, where he is associate professor of surgery. The awards — silver goal posts — go to ex-gridders who played their last collegiate games in 1936; criteria were the quality of the candidates' records in their professions and their general effectiveness during the intervening 25 years since they played college football.

Dr. Albert M. Potts, professor of ophthalmology in the department of surgery and director of research in ophthalmology at the University of Chicago, has been given the annual Friedenwald Award of the Association for Research in Ophthalmology for his outstanding contributions to ophthalmic research. Dr. Potts is known for his work on the development of a television ophthalmoscope and for studies on drugs poisonous to the eye, on the mechanism by which cornea and lens remain transparent, and on electrical currents created when the eye reacts to light.

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Hospital's Seminars Modified

The North Shore Hospital has modified its monthly seminars on the training of general practitioners at the hospital on the second Wednesday of each month at 10 a.m.

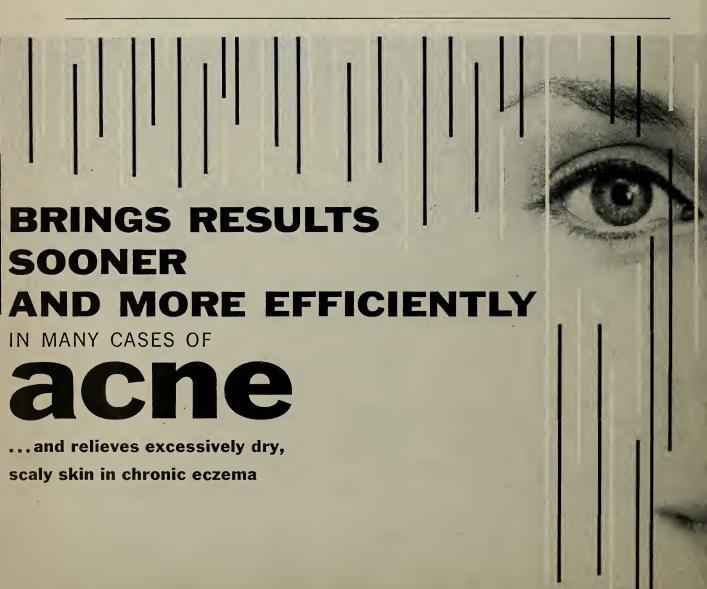
Subject matter will deal with techniques of interviewing patients for anamnestic, diagnostic, psychotherapeutic purposes. Primary emphasis will be upon the problems encountered by the students in their day-to-day practice. The format will be group discussion under the leadership of Dr. Marc Nissenson and Dr. Richard Saskill. Recorded or filmed case material will occasionally be used for demonstration.

Deaths

George Halperin*, Chicago, a graduate of Rush Medical College in 1905, died November 7, aged 80. He joined the staff of the *Journal of* the American Medical Association in 1931 as a part-time writer of abstracts and editorials and in 1940 became full-time assistant editor. In recent years he was associate editor and editor of the Medical Abstract Section. A native of Russia, Dr. Halperin came to Chicago in 1896 and began teaching internal medicine at Rush Medical College in 1907. At one time he taught anatomy at the University of Illinois and surgery at Northwestern University Medical School and served as attending surgeon at Wesley Memorial and Cook County hospitals.

In 1950 he was president of the Chicago Literary Club and from 1953 to 1955 conducted a lecture series in Israel on medical journalism. A fellow of the International College of Surgeons, he practiced in Chicago over 35 years and served in the U.S. Army Medical Corps in World War I.

ERNST HAASE*, Chicago, a graduate of Friedrich-Wilhelms University, Berlin, in 1923, died October 10, aged 66. Before coming to the United States he was chief assistant physician in the neurology department at the fourth Uni-



versity Clinic-Hospital, Berlin, in 1930-32. From 1929-33 he was head of the Clinic for Alcoholics and Drug Addicts in Berlin.

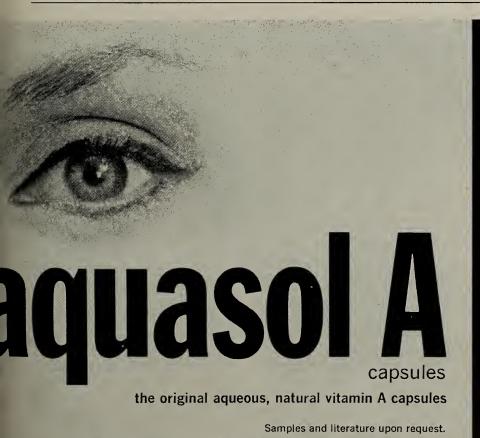
In 1948 he was certified in psychiatry and neurology and was on the staffs of American, Michael Reese, and Illinois Masonic hospitals and served as assistant clinical professor in neurology at the University of Illinois and consulting neurologist at the Illinois Eye and Ear Infirmary.

Dr. Haase joined the adjunct staff of the Psychiatry Section, Neuropsychiatry Clinic at Mt. Sinai Hospital, Chicago, in 1941 and left in 1945 to be an associate in the neurology department at Cook County Hospital, staying until 1950. In 1942 he became assistant clinical professor of neurology at the Neuropsychiatric Institute of the department of neurology and neurological surgery at the University of Illinois and in 1947 a full professor, until his death.

His memberships included the American Psychiatric and Central Neuro-psychiatric associations. JOHNSON F. HAMMOND, Chicago, a graduate of Rush Medical College in 1910, died December 5, aged 78. Editor emeritus of the *Journal of the American Medical Association*, he had served the *Journal* nearly 40 years. In 1922 he joined the publication's staff as news editor and, after serving as assistant and associate editor, was appointed editor in 1958. In 1959 he became editor emeritus.

Dr. Hammond was a first lieutenant in the U.S. Army Medical Corps from 1912 to 1922, and in World War II, while in the Surgeon General's office, organized and edited the Bulletin of the U.S. Army Medical Corps. He receive the Legion of Merit for this work.

Frank D. Leahy, Chicago, a graduate of Loyola University School of Medicine in 1926, died October 20, aged 64. A veteran of both World Wars, he had been a staff member of the West Side Veterans Administration Hospital since 1945 and from 1925 to 1942 was Elmhurst's health commissioner.



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ROBERT F. LINDEN, Chicago, a graduate of the Jenner Medical College in 1911, died August 6, aged 76.

Gustav A. Ludwics, East St. Louis, a graduate of Washington University School of Medicine, St. Louis, in 1907, died July 28, aged 82.

ALLEN P. MILLIKEN, Kankakee, a graduate of the Chicago College of Medicine and Surgery in 1916, died August 7, aged 70.

Walter N. Schroeder, Chicago, a graduate of the University of Illinois College of Medicine in 1958, died October 19, aged 31. He conducted brain wave studies with Chicago's Brain Research Foundation and was on the staff of the consultation clinic for epilepsy at the University of Illinois Hospital until shortly before his death.

George H. West*, retired, Highland Park, a graduate of Northwestern University Medical School in 1903, died October 7, aged 92. A member of the 50-Year Club of the Illinois State Medical Society, he retired 15 years ago and moved to Highland Park from Armstrong, Iowa, where he had practiced 42 years.

Roscoe C. Whitman*, retired, Morris, a

graduate of Rush Medical College in 1907, died October 14, aged 80. A physician in Morris from 1909 until he retired in 1953, he belonged to the 50-Year Club of the Illinois State Medical Society. During World War I he was a medical examiner on his local draft board and also served with a portion of the U.S. Army attached to the British Medical Corps; in World War II he was chairman of the Grundy County Selective Service Board. He belonged to the Tri-State Medical Association.

WILLIAM E. WHITE, retired, Chicago, a graduate of Howard University College of Medicine, Washington, D.C., in 1908, died November 18, aged 77. Before retiring a year ago he had practiced 50 years on the South Side.

HARRY O. WILLIAMS*, retired, Centralia, a graduate of the St. Louis College of Physicians and Surgeons in 1898, died October 20, aged 88. In practice in Centralia from 1912 until he retired in 1953, Dr. Williams was a member of the 50-Year Club of the ISMS and an emeritus member of the society.

*Indicates member of Illinois State Medical Society.



Abstract of Council Actions

Meeting of January 14, 1962



LEGISLATIVE DANGERS TO BE BROUGHT HOME TO PHYSICIANS

Edwin S. Hamilton of Kankakee, president of the Society, said that despite all the efforts which have been made to inform members regarding the legislative dangers facing medicine and to arouse concerted action, a large segment of the profession still seems unaware of the situation or is doing nothing about it.

Dr. Hamilton stressed the need for bringing the situation to the attention of all physicians by personal messages. He urged the holding of county medical society dinner meetings for this sole purpose within the next six weeks. He said locally elected state or national representatives, presidents and secretaries of local bar, dental, pharmaceutical, and nurses associations, and a staff representative of ISMS, should be invited.

By action of the Council, each councilor was directed to request that special meetings be called by all county societies in his area. In some instances, two or more societies might combine in one meeting. The advantages of the Kerr-Mills Act and the dangers of the pending Anderson-King Bill will be pointed out.

NO OFFICIAL POSITION ON RECENT AHA AND BLUE CROSS PROPOSALS

The Executive Committee reported it had considered the recent announcement of the American Hospital Association and Blue Cross concerning their recommended program for the care of the aged. There are two basic differences with the position of organized medicine: (1) an admission by the two groups that (federal) government assistance is necessary to implement a national Blue Cross program, and (2) that the individual should receive assistance on the basis of income only, without a means test determination. The AHA did go on record against the King-Anderson proposal.

Based on the present information, the committee reported that "it is believed advisable that any comment by officers and staff of ISMS should be that we are for the Kerr-Mills program, and that at the present time we have no official position on the program recommended by AHA and Blue Cross." It is felt advisable to wait until specific legislation is introduced before specific comment is made.

REQUEST COUNTY MEDICAL SOCIETY STAND ON CARE FOR AGED
The Council adopted a recommendation of the Executive Committee that each county medical society be requested to make a statement of policy endorsing the AMA's stand on federal aid to medical care for the needy aged in order to demonstrate solidarity of the profession. This position would favor a fair trial for the Kerr-Mills Law and oppose the pending King-Anderson Bill.

FORD FOUNDATION APPROVES \$25,000 IMPARTIAL MEDICAL TESTIMONY GRANT Mr. Robert L. Richards, executive administrator, reported that the Ford Foundation had approved the ISMS requests for a grant of \$25,000 over a period of two years for an experiment in the use of impartial medical testimony in the state courts of Illinois. The grant contains certain qualifications, one of these being that \$15,000 must be raised through other sources.

In order to get the program under way, the Council authorized an advance of \$1,000 by the ISMS toward expenses. This is to be refunded when the grant

funds are made available.

CONSIDER STUDY ON FETAL MORTALITY IN ILLINOIS

Dr. John Lester Reichert, Chicago, chairman of the Committee on Child Health, reported that a study is underway to determine the cost of a survey of factors influencing fetal mortality in Illinois. Dr. Reichert said that although the state-wide rate of newborn deaths was 16.7 per 1,000 live births there were areas in Illinois where the rate ran as high as 50.

OPPOSE TRANSFER OF CRIPPLED CHILDREN'S SERVICES

The Council, on recommendation of the Committee on Child Health, went on record opposing the inclusion of the Division of Services for Crippled Children under a proposed new state department. The opinion is that the division should be continued under the University of Illinois and that a physician should remain at the head.

Dr. William H. Schowengerdt, Champaign, chairman of the Committee on Constitution and Bylaws reported that the committee recommends numerous changes in the Constitution and Bylaws. The Council voted to refer these to the House of Delegates:

These recommendations included:

(1) Deletion of citizenship as a prerequisite for membership.

(2) Change in name to the Illinois Medical Association, to avoid confusion with departments of the State of Illinois.

(3) Changes in "presiding officer" and "assisting presiding officer" to "speaker" and "vice speaker," respectively.

- (4) Granting of power to the speaker to appoint reference committees of the House of Delegates after consultation with the president and presidentelect.
- (5) Election of the secretary-treasurer by the Council, from its membership, for a term of one year at the first meeting of the Council following the annual meeting.

(6) Change of "annual meeting" to "annual convention."

(7) Changes in the manner of references to the reference committees. The Committee on Constitution and Bylaws said that any suggested further changes in the constitutional committee structure will hinge on recommendations which may be made by the Committee to Study Committees.

POSITION OF ISMS WITH RESPECT TO OSTEOPATHS

Because the AMA House of Delegates in June 1961 made it possible for the California Medical Association to recognize graduates of osteopathic schools, the Executive Committee was asked for a statement of the present position in Illinois with respect to voluntary association of physicians with osteopaths. The Executive Committee reported that:

"In view of the fact that the House of Delegates of ISMS has not had an opportunity to consider the action of the AMA, there is no change in policy

in Illinois....

"Any voluntary association with osteopaths is unethical. This includes association on staffs of hospitals which are private and are not maintained through tax revenues. On the other hand, it excludes association with osteopaths on staffs of hospitals which are tax supported, for these institutions are operated by law."

NEW PROJECTS OF COMMITTEE ON PUBLIC RELATIONS

Dr. Eugene T. McEnery, Chicago, reporting for the Committee on Public

Relations, said newly completed projects of the committee include:

(1) A newspaper cartoon series, "Dr. Quiddity," dealing with medical subjects; (2) a "Safeguard Your Health" TV series featuring actor Burgess Meredith and dealing with modern preventive medicine, careers in medicine, booster immunizations, mental and physical fitness, and the family physician; (3) a radio record series covering the same subjects; (4) a "Safeguard Your Health" weekly medical column for newspapers.

Dr. McEnery also reported that a State-wide Illinois "Community Health Week" is being planned for the week of October 21. It is the first project of its type and will highlight medical progress at the community level. Promotion material will be prepared by ISMS for county medical societies.



The ILLINOIS Medical Journal

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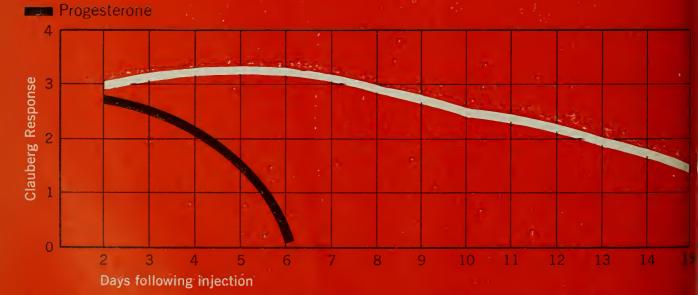
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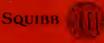
Borman, A.: Laboratory Report on the Duration of Action of 17-Alpha-Hydroxy-progesterone-n-Caproate (Delalutin). The Squibb Institute for Medical Research, May 17, 1955.

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References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times 89:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. 173:1783 (Aug. 20) 1960.

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AS I SEE IT FROM '360'

By Robert L. Richards Executive Administrator

On January 22 to 25 a Contingent of nine physicians and three staff members of ISMS attended the Public Affairs Conference sponsored by the U. S. Chamber of Commerce in Washington, D. C. It was a fine conference, but visitations with Congressmen and Senators from Illinois were more interesting, personally invigorating, and challenging. Our Congressmen left their seats in the halls of Congress to meet our delegation. They met with us at dinner and also arranged for private chats with men who came from their particular congressional districts.

Our legislative program should be such that no Congressman nor Senator should have a week at his desk without being visited or written to by some physician in his constituency.

Did we accomplish anything? I think so. Let me explain. At least four of our number had never participated in this type of thing before. They were both amazed and educated. The first meeting of an individual with his congressman in the congressman's office is a real experience worthwhile beyond expression. It is especially challenging if that particular congressman happens to disagree with your philosophy or position on a certain measure. For example, one Congressman from Chicago will tell you that he loves the medical profession, but will and must favor the King-Anderson proposal if it comes to the floor for a vote. This doesn't mean, however, that he will always be against our position on every bill that comes before Congress. Yes, he can and should be cultivated by ISMS. Furthermore, physicians in his district should let him know their feelings.

Likewise, we visited with Senator Douglas. It would be fallacious, I am sure, if we thought we might change his position on the use of the Social Security System for financing medical care for the aged. But believe it or not, he

listened to our representatives for over one hour. His administrative assistant took frequent notes, he requested further information on what is being done in Illinois for the implementation of the care of the aged, and he promised to consider additional facts and figures which we will provide. Perhaps the next time he speaks, his criticism of the medical profession as an organized group will be modified. His conversion to a conservative position would be impossible, but he provided a willing ear to listen, and pehaps will make a proper adjustment of misleading facts provided from other sources. This could be a step in the right direction.

In order to place our visit to Washington in its proper perspective, let it be made quite plain that we have supporters for our position. But they say they need our help to stand firm and hold fast. Our help means you, your friends, your families, and your patients. Senator Dirksen has frequently spoken quite openly in our behalf. Congresswoman Marguerite Stitt Church, Congressmen Arends, Anderson, Springer, Michel, Hoffman, Mason, Collier, Findley, Derwinski all expressed themselves as favoring our position. Mr. Chiperfield, who was out-of-town, has previously expressed himself as being in support of our position. Others are not quite so sure, and some others we were unable to contact for discussion.

This simply means that we have our work cut out for us, not just for tomorrow, but for this fall, next year, and the next year, and forever if we are to make our system of government function properly. Each of us has the right to petition his representatives in Congress. Is it not possible that we fail to do so because we don't care? I think we fail because we think it doesn't matter. Believe me, I am more convinced than ever that it makes a great difference when our representatives do hear from us. Have you visited yours, or written to him lately?

IN ORAL PENICILLIN THERAPY COMPOCILITIN®-VK

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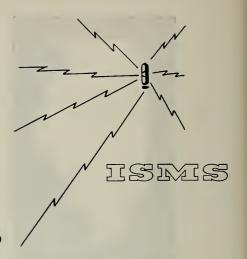
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. **2.** J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. **3.** J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. **4.** W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.





Announcements

Dr. Percival Bailey Is Guest Lecturer

Dr. Percival Bailey, director of research, Illinois Department of Mental Health, will give the annual D. J. Davis Memorial Lecture on Medical History. His address, "Effort for Mental Health in the State of Illinois," is to be on April 18 at 1:00 p.m., Room 221 of the Dental-Medical-Pharmacy Building of the University of Illinois.

Medical History Lectures Slated

The Society of Medical History of Chicago invites members and guests to an open meeting at 8:00 p.m., Wednesday, February 21, in the fourth floor Assembly Room of the Institute of Medicine.

Speakers for the evening will be Drs. John H. Talbott, editor, *Journal of the American Medical Association*, "Gout Through the Ages," and Burton J. Grossman, associate professor of pediatrics, University of Chicago, "The History of Rheumatic Fever."

Applied Basic Science Course Is Open

The staff of the Decatur and Macon County Hospital in Decatur is presenting its second annual seminar in Applied Basic Science at the hospital. The course, which began in January, will run through April 4 and is being held each Wednesday 2:15 to 5:15 p.m.

It continues February 21 with "Pathophysi-

ology of Gastric Secretion"; February 28 "Metabolism of Calcium and Bone"; March 7 "Psychopharmacology"; March 14 "Role of Catecholamines and Related Subjects"; March 21 "Medical Genetics"; March 28 "Intermediate Metabolism: Diabetes Mellitus"; and April 4 "Intermediate Metabolism: Atherosclerosis."

Clinical correlation and integration is emphasized, and lectures followed by a clinical phsyiological conference is the format. Last year's panels are replaced by open discussion from the floor.

To enter the course contact the registrar, Robert L. Harris, assistant administrator at the hospital, 2300 N. Edward St.

Study and Travel

The University of California will conduct a Clinical Postgraduate Program in Mexico City, February 21 through March 1 in cooperation with the National Autonomous University of Mexico School of Medicine. Concurrent sessions will be provided on internal medicine, surgery, dermatology, obstetrics and gynecology, pediatrics, nutrition, and cardiology.

Tuition will be \$100, and travel cost from Chicago will total \$354.50. This includes a round trip by jet, hotel room, two special dinners, and some transportation in Mexico.

A course on internal medicine, surgery, dermatology, obstetrics and gynecology, pediatrics, radiology, and narcotics control is planned

(continued on page 125)

Announcements (continued from page 122) for April 7-29 in Japan and Hong Kong.

Requests for more information on these courses should be made to Dr. Thomas H. Sternberg, assistant dean in charge of post-graduate medical education, University of California Medical Center, Los Angeles 24.

Mayo Clinic Offers Clinical Program

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery. The Clinical Reviews will be given in two identical sessions March 26-28 and April 2-4.

Category I credit may be obtained by members of the American Academy of General Practice or the College of General Practice of Canada.

Registration is limited; the fee is \$10. Those wishing to attend should contact M. G. Brataas, Mayo Clinic, Rochester, Minn.

PG Courses

The sixth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 25-28 at the John B. Murphy Memorial Auditorium, Chicago.

The course is dedicated to the late Dr. Philip Lewin, renowned orthopedic surgeon who cooperated for many years in the efforts of the Chicago Committee on Trauma and was one of the founders of the American Academy of Orthopedic Surgeons.

A distinguished faculty of eight guest speakers and teachers from the five medical schools of Chicago will discuss many phases of trauma. Ample time is allotted for question and answer periods.

The registration fee will be \$75. Residents and interns are admitted free by letter from the chief of services. This course is acceptable for 31½ hours of category II credit by the American Academy of General Practice.

A schedule of six postgraduate courses on

advanced medical practice and clinical research, undertaken by the American College of Physicians, began in January and concludes with two March courses.

"Gastroenterology: Basic Principles and Treatment" will be given March 5-9 at the University of Michigan Medical School, Ann Arbor; and on March 12-16 "Selected Subjects in Internal Medicine" at the University of Chicago Clinics. Dr. H. Marvin Pollard will direct the first course, and Drs. Wright Adams and Robert G. Page will co-direct the second.

ACOG Meeting to Have Seven Seminars

Seven Correlated Seminars will be offered during the annual Clinical Meeting of the American College of Obstetricians and Gynecologists at Chicago's Palmer House April 2-4. The seminars, each divided into four one-hour sessions, are designed to permit extra time for study in greater depth. They will be scheduled concurrently with the shorter Clinical Conferences.

Subjects will be "Toxemias of Pregnancy," "Infertility," "Neuropsychiatric Complications in Obstetrics and Gynecology," "Radiation Therapy in Gynecologic Cancer," "Reproductive Physiology," "Heart Disease in Pregnancy," and "Diagnosis and Management of Menstrual Disorders."

Advance registration is open to Fellows of the college in January; other physicians also may register for a fee of \$25. More details may be obtained by writing Donald F. Richardson, Executive Director, 79 W. Monroe St., Chicago 3.

Jottings

An introductory course on "Expanded Surgery of the Nasal Septum and Closely Related Structures" will be presented at the St. Michael Hospital, Milwaukee, May 16-19, with the cooperation of the American Rhinologic Society. For further information write the Educational Committee of the Society, 530 Hawthorne Pl., Chicago 13.

The West Virginia Academy of Ophthalmoloy and Otolaryngology will meet at the Greenbrier Hotel, White Sulphur Springs, W. Va., April 23-25. Speakers included: Dr. Ramon Castroviejo, New York; Dr. Frank Costenbader, Washington, D.C.; Dr. Kelvin A. Kasper, Philadelphia; Dr. Frederick Guilford, Houston, and Mr. Philip Salvatori, New York City.

Registration will be \$25. For further information write the Secretary, Dr. Worthy W. McKinney, 109 E. Main St., Beckley, W. Va.

Restoration Center Opened at Hines

Hines Veterans Administration Hospital opened a new Restoration Center December 1 where individualized and group rehabilitation will attempt to restore aging and disabled patients to community life.

Sixty patients were admitted in December and an additional 60 in January. In each group are both medical and mental convalescents whom physicians have decided can be rehabilitated to outside living within one year.

Fellowships and Scholarships

Fifteen fellowships of \$400 each and a number of scholarships to help further the skills of professional persons working with the crippled are available from the National Society for Crippled Children and Adults.

A special course will be given to fellowship winners June 11 through July 6 at the Institute of Physical Medicine and Rehabilitation in New York. Applicants must be counselors, employment interviewers, placement specialists, and other qualified persons.

Scholarships are available to physicians, physical and occupational therapists, speech pathologists and therapists, teachers, and other qualified persons.

Deadlines for filing applications are March 15 for fellowships and April 1 for scholarships. Forms and further information may be secured from the Personnel and Reporting Service of the National Society, 2023 W. Ogden Ave., Chicago 12.

Clinics for Crippled Children

March 1 Effingham (General), St. Anthony Memorial Hospital March 1 Peoria (Cerebral Palsy), Roosevelt School

March 1 Sterling, Community General Hospital

March 2 Chicago Heights (Cardiac), St. James Hospital

March 6 Carrollton, First Baptist Church

March 7 Carmi, Carmi Township Hospital

March 7 Hinsdale, Hinsdale Sanitarium

March 8 Bloomington (Cerebral Palsy (p.m.), St. Joseph's Hospital

March 8 Springfield, St. John's Hospital

March 13 East St. Louis, Christian Welfare

March 13 Peoria (General), Children's Hospital

March 14 Champaign-Urbana, McKinley Hospital

March 14 Joliet, Silver Cross Hospital

March 15 Elmhurst (Cardiac), Memorial Hospital of DuPage County

March 15 Rockford, St. Anthony's Hospital

March 15 Sparta, Sparta Community Hospital

March 20 Alton (General), Alton Memorial Hospital

March 20 Danville, Lake View Hospital

March 21 Evergreen Park, Little Company of Mary Hospital

March 21 Jacksonville, Passavant Hospital

March 22 Decatur, Decatur and Macon County Hospital

March 27 Peoria (General), Children's Hospital

March 28 Centralia, St. Mary's Hospital

March 28 Elgin, Sherman Hospital

March 28 Springfield (Cerebral Palsy), Memorial Hospital

March 29 Effingham (Rheumatic Fever), St.
Anthony Memorial Hospital

Corrections

Solon N. Blackberg, M.D., is the author of the paper "Justifiable Abortions — Medical and Legal Foundations — An Abstract" that appeared in the January 1962 JOURNAL page 57.

Please change Reference Sheet No. 27 as follows: Skin test antigen for mumps is available from Eli Lilly only. Skin test antigens for Chancroid and Tularemia not commercially available.

The ILLINOIS Medical Journal

Official Journal of the Illinois State

Medical Society

February, 1962

Volume 121, No. 2

Dangers of Using Glutethimide: Addictive Qualities, Symptoms of Intoxication, and Withdrawal Convulsions

BERNARD L. GREENE, M.D., SAMUEL LIEBMAN, M.D., F.A.P.A., and NOEL LUSTIG, M.D., Chicago

GLUTETHIMIDE (DORDEN®), a valuable nonbarbiturate sedative drug widely prescribed and commonly thought of as innocuous, can be not only habit-forming but dangerous as well. In our case there was addiction, signs of chronic toxicity, and convulsions when the patient abruptly stopped taking Doriden. We suggest that all hypnotic and sedative drug prescriptions be written *Not To Be Refilled* to prevent excessive self-medication.

Review of the Literature

Addiction to Doriden^{1,2,3,4} was first reported in 1956 by Burnstein.¹ Rogers⁴ in 1958 reported a patient who preferred this drug to barbiturates, alcohol, and tranquilizers. In 1959 Lloyd and Clark⁵ reported that Doriden seemed to share addictive properties and withdrawal symptoms similar to those of the barbiturates.

Smith and Pino⁶ reviewed the literature in 1960 and pointed out, in the 27 cases they studied, evidences of serious intoxication with

seven fatalities. The signs of acute intoxication^{5,7,8} progressed from garbled speech, flushed face to areflexia, facial paralysis, coma, respiratory and circulatory collapse, and death. The post-mortem findings included cerebral edema, perivascular hemorrhage, hemorrhage into the galea, and pulmonary congestion.

Convulsive reactions, reported by Rodgers and by Lloyd and Clark usually started with "tonic contractions of the limbs and facial muscles. Between seizures a mental state usually an admixture of post-ictal and toxic psychosis develops which may or may not show memory deficit." Several of the authors reviewed felt that Doriden should be classified with alcohol, barbiturates, and meprobamate as one in which the sudden withdrawal of the drug may be followed by convulsions.

Pharmacology

Doriden belongs to the dioxypiperiden group of anticonvulsants.⁹⁻¹¹ Its chemical configuration is similar to the barbiturate nucleus. The absorption is variable. Sleep usually follows when the blood level reaches 2 to 3 mg. per cent. Death has followed the ingestion of 10

grams. It is reported that the intake of alcohol contributes to the effectiveness of Doriden, either by increased absorption, by potentiating the drug, or by a combination of both.

Doriden is capable of producing a deep restful sleep even in elderly patients because of its depressant effects on the central and autonomic nervous systems. Ladwig¹¹ reported that 82 per cent of the cases he studied on EEG showed "20 to 30 per second fast activity with voltage ranging from 20 to 100 microvolts" which he also found in patients receiving other sedatives, i.e., secobarbitol and chloral hydrate.

In our patient excessive administration of Doriden was followed by signs of chronic toxicity manifested by incoherent speech, loss of coordination, and frequent falling with multiple contusions. She generally gave the impression of being intoxicated. Convulsions followed when the patient decided, on her own, to discontinue the drug.

Case Report

Mrs. C., a 30 year old white housewife, was first seen about a year prior to her present emergency hospitalization for neurotic complaints and marital disharmony. During the initial interview she reported her inability to stop taking Doriden, which had been prescribed two and one-half years previously with the assurance that it was not habit-forming.

After three months of psychotherapy she was able to discontinue the drug but resumed taking it without advising her therapist when he began to see her husband in an attempt to stabilize the marriage. Two months before her emergency hospitalization she stopped therapy but telephoned about once a week complaining about her marriage and also mentioned, incidentally, that she was taking Doriden, increasing the dosage without effectiveness. At times she would fall and bruise herself. Further, her husband told her that occasionally her speech was incoherent. Hospitalization was advised repeatedly but refused.

Her maid called at 6 a.m. the morning of her hospitalization and stated that her mistress was very ill. Mrs. C. then took the telephone, agreed to enter the hospital, and then suddenly became incoherent and fainted. Her maid picked up the telephone and was advised that hospital arrangements would be completed immediately. On admission the patient was conscious but appeared groggy. She had had a convulsion en route.

Physical examination revealed a pulse of 120, blood pressure 150/90, ecchymotic areas over body, tongue bitten and slightly bloody. Pupils were equal and reacted to light and accommodation. Otherwise complete physical and neurological examinations and laboratory tests were essentially normal. Blood and urine levels of Doriden were not determined. 12,13

Shortly after admission she said, "I've been taking too much Doriden. I've been falling around the house. I don't remember anything." She didn't remember exactly how much or how often and added, "Recently I became hysterical. I felt like I was going to pass out. I felt the pain; I couldn't relax. I got frightened and called Dr. Greene."

The patient was started on Doriden, 1 Gm. four times daily; Dilantin® Sodium, 1½ grains three times daily, and multiple vitamins (parentally and orally). The Doriden was gradually eliminated over eight days and the patient was discharged on the eleventh day. An EEG taken the day before discharge was normal both during wakefulness and drowsiness. Other laboratory tests were normal.

Mrs. C. later said "I told my maid to call you. While talking to you on the phone my maid later told me that my legs got stiff, that I began to bite my tongue and passed out cold with violent convulsions. She said I had another convulsion soon after but not as severe. I don't remember all this, but that I was completely calm when I went with the ambulance driver. I remember passing out in the ambulance. I was taking six Doridens a day. I started to taper off that week, but I made a mistake and deliberately ran out of Doriden. For 24 hours before I called you I had taken none."

Summary and Conclusions

A case of self-induced addiction to Doriden, chronic intoxication, and convulsive phenomena following withdrawal is reported. Three successive convulsions preceded emergency hospitalization. The patient made an uneventful recovery on decreasing doses of Doriden in combination with Dilantin.

Doriden is a valuable drug with widespread usage. We recommend that prescriptions be marked "Not To Be Refilled," so that the prescribing physician remains in complete control of its administration at all times.

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Mvocardial Infarction

The subjects of this study were 100 survivors of a first myocardial infarction. They were selected from 186 patients with coronary heart-disease in order to obtain a homogeneous

group. For five years, 50 of these men received a potent oestrogen and 50 were given lactose.

In the oestrogen group, significant reduction of the serum-cholesterol and the cholesterol/phospholipid ratio in the serum was evident throughout the five years of treatment. In the control group there was no significant change in the serum lipids.

The morbidity and mortality of the two groups did not differ significantly during the five years; 18 men in the oestrogen group and 18 men in the control group had further myocardial infarction. Analysis of morbidity and mortality according to age, the pretreatment level of serum-cholesterol, the site of the first myocardial infarct, the presence of obesity, and the subsequent development of hypertension, angina, and congestive heart-failure, showed no significant difference between the groups.

This study suggests that continued reduction of the serum lipids does not improve prognosis once myocardial infarction has occurred. M. F. Oliver, F.R.C.P.E., G. S. Boyd, Ph.D. Influence of Reduction of Serum Lipids on Prognosis of Coronary Heart Disease. Lancet, September, 1961.

Dr. Edward R. Annis Annual Banquet Speaker

Edward R. Annis, M.D., Miami, Florida, the physician who, in the past year, has emerged as the spokesman for medicine, will be the featured speaker at the Illinois State Medical Society Annual Banquet, on May 16, 1962 at the Sherman House, Chicago.

Dr. Annis's emergence as a top spokesman for the A.M.A. came when he tangled with W. Averell Harriman during a hearing on aging. He has debated such national figures as Senators Jacob Javits (R-N.Y.), William Proxmire (D-Wis.), Hubert Humphrey (D-Minn.) and Mr. Walter Reuther, A.F. of L.-C.I.O.

Attend the Annual Meeting of the ISMS—May 13-17—Chicago.

Peptic Ulcer Disease in Young Males Under Twenty-One

WILLIAM M. LUKASH, M.D., FRANCISCO R. SIFRE, M.D., and PAUL T. MOORE, M.D., *Great Lakes*

Peptic Ulcer Disease is probably the most frequent organic gastrointestinal problem affecting man. It has been stated that from 5 to 10 per cent of most populations develop ulcers.¹ Duodenal ulceration occurs at any age but is most frequently found in the 30 to 50 year age group,^{1,2} whereas gastric ulceration seems to occur most frequently in the 50 to 70 year age group.³ The present study is a review of some of the clinical aspects of peptic ulcer disease in a young male population under age 21. It became apparent to us that such a study might provide some interesting data in comparing the disease in this group with that in the general population.

Material

All patients under 21 years of age hospitalized for peptic ulcer disease at the U. S. Naval Hospital at Great Lakes during the five-year period 1955 to 1960 were selected for study. There were 165 male patients with an age range of 17 to 21 years, average of 19.3 years.

These cases represent a selected group inasmuch as all patients were in the active Naval service when admitted to the hospital. On the other hand, we believe they may be regarded as representative of this age group as seen in general clinical practice since anyone with the disease is unfit for active Naval duty and is hospitalized. However, they do not necessarily represent the most severe nor the complicated cases of petic ulcer disease ordinarily seen at a civilian hospital.

Department of medicine, U. S. Naval Hospital, Great Lakes The diagnosis was established roentgenographically by demonstration of an ulcer crater in the stomach or duodenum or by evidence of deformity and irritability of the duodenal bulb, or by surgery.

Incidence

As expected, about half of the cases of peptic ulcer disease occured in the patients 20 and 21 years old. There were 5 cases of gastric ulcer and 160 cases of duodenal ulcer. The usually reported ratio of duodenal to gastric ulcers confirmed by radiologic examination is approximately 10 to 1.⁴ In our series the ratio was much higher: about 30 to 1.

Fifty-three of the patients had a previous history of peptic ulcer disease at the time of their hospitalization. Thus, 32 per cent of the cases represented recurrence.

The total hospital stay averaged 45 days per patient. This must be evaluated in light of the fact that military personnel must be considered fully fit for active duty before hospital release. Of the 165 patients, 64 (39%) were surveyed from the service because of disability incurred by their disease.

Heredity

A high incidence of peptic ulcer disease is found among parents and siblings of ulcer patients. In one reported group of 932 patients, the familial incidence of peptic ulcer was 40 per cent, including 26 sets of twins with ulcers after adolescence.⁵ In our group 37 patients (22%) had a familial history. Peptic ulcer disease was found in siblings of the patients 11 times (7%),

in their fathers 18 times (11%), and in their mothers 8 times (4%).

Complications

1. Bleeding. The incidence of bleeding in peptic ulcer disease as determined from other hospital data approximates 30 per cent.⁶ In our group with 56 episodes of bleeding among 43 of the patients, the incidence was 26 per cent. Bleeding was described as melena in 30 episodes and frank hematemesis in 26 episodes. In 14 patients hemorrhage was severe enough to require blood transfusion. They represented 8.5 per cent of the whole group and 32.6 per cent of those with bleeding. The death rate due to hemorrhage in peptic ulcer disease is reported as about 3 per cent for all cases and about 14 per cent for those with massive hemorrhage.⁷ In our series there was one death (7.1%) among the 14 cases requiring transfusions; perforation occurred to complicate the problem. Surgery was performed in one case of massive bleeding.

2. Perforation. This complication has been estimated to occur in approximately 8 per cent of peptic ulcers.8 A recent report shows that perforation accounted for 22.5 per cent of all admissions for ulcer at the Cook County Hospital over a 20-year period. In the same series, 37.7 per cent of the perforations were gastric, and 62.2 per cent were duodenal. The total mortality rate was 24 per cent, which is in keeping with the known severity of such complication.9 It has been stated that peptic ulcer perforation is comparatively rare before the age of 25 years.6 In the present study, however, there were 12 cases of perforation, 7.3 per cent of the group. Duodenal perforation occurred in 8, and 4 had gastric perforations, giving a ratio of 2 to 1. It should be noted that of the 5 cases of gastric ulcer in the whole series, 4 were perforated. The suggests that gastric ulcer disease may represent a more severe condition in this young age group and is subject to a greater incidence of perforation.

3. Obstruction. Abnormal gastric retention secondary to pyloric obstruction in peptic ulcer disease is estimated to occur in approximately 5 to 10 per cent of cases. It has been stated that obstruction is the most frequent indication for surgical treatment of peptic ulcer. 10 In our

study there were 6 cases of obstruction, giving an incidence of 3.6 per cent; 2 required surgery.

Surgical Treatment

Surgery for peptic ulcer disease is believed to be indicated in approximately 10 to 15 per cent of patients of all ages. In our series, 17 patients (10.3%) had surgery: 12 because of perforation, 2 for pyloric obstruction, and 1 for severe hemorrhage. The remaining 2 patients underwent laparotomy for suspected perforation that was not substantiated at the time of operation. Five partial gastrectomies were performed: 2 for obstruction, 2 for perforation, and 1 for massive hemorrhage. Ten cases had simple closure of a perforation.

Peptic Ulcer and Corticosteroid Therapy

The increased incidence of peptic ulcer in patients under corticosteroid therapy has been reported. 12,13,14 In our series, 6 patients developed an ulcer. Four of them were under treatment for acute rheumatic fever, 1 for iritis, and 1 for sarcoidosis. All were receiving therapeutic doses of steroids, the lowest being 40 mg. of prednisone daily and the highest 100 mg. of prednisone per day. The shortest period of therapy prior to symptoms or signs of peptic ulcer was 23 days, the longest 46 days. None of these patients had a family history of peptic ulcer, no history of previous peptic ulceration, nor significant gastrointestinal complaints. One patient had had congenital hypertrophic pyloric stenosis corrected surgically at infancy with no subsequent difficulty. In 2 cases the ulcer was gastric, and in 4 duodenal, in contrast to several reports in which gastric ulcer has predominated.14,15,16

Ulcers developing secondary to steroid therapy have been associated with a high incidence of bleeding and perforation.¹⁷ This was borne out in the 6 cases in this study. Three patients required transfusions. Two with gastric ulcer required surgery for resulting perforation, one associated with massive hemorrhage and the patient died despite partial gastrectomy. As indicated by the morbidity and mortality in this small group of "steroid ulcers," it would appear that males under 21 years are very susceptible to the adverse sequelae of this condition.

Summary of Comparative Study with Other Groups of 165 Male Peptic Ulcer Patients Under 21

HEREDITY C	THER REPORTS	OUR REPORT		
Familial Incide	nce 40% 22%	% (Siblings 7%;		
		Fathers 11%;		
		Mothers 4%)		
INCIDENCE				
Gastric	10%	3%		
Duodenal	90%	97%		
COMPLICATIONS				
1. Bleeding	30%	26%		
Deaths	3%	1.7%		
2. Perforation				
Incidence 8	8% (22.5%)*	7.3%		
Gastric	37%*	33.3%		
Duodenal	62%*	66.6%		
3. Obstruction	5-10%	3.6%		
SURGICAL TREATMENT				
	10-15%	10.3%		

^{*}Cook County Hospital

Summary and Conclusions

Results are summarized in table.

A clinical study has been made of 165 patients between the ages of 17 and 21 who suffered from peptic ulcer disease. Duodenal ulcer predominated over gastric ulcer in a ratio of 30 to 1, which is probably higher than the ratio in the general population. There was a familial incidence of this disease in 22 per cent of cases.

Incidence of complications from peptic ulcer was bleeding 26 per cent; perforation 7.3 per cent; and obstruction 3.6 per cent. These figures compare favorably with the reported incidence of complications in patients with peptic ulcer disease. On the other hand, perforation occurred in 4 of the 5 cases of gastric ulcer, suggesting that gastric ulceration in this age group may be a more severe condition than it is in the general population.

In the whole series of 165 cases, surgery was indicated in 10.3 per cent of cases.

Six patients developed peptic ulcers while on corticosteroid therapy, 4 duodenal and 2 gastric. They were associated with a high incidence of complications and with one death, tending to indicate that patients in this young age group do not tolerate well this particular type of ulcer.

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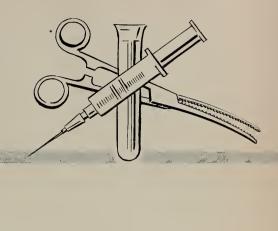
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We wish to acknowledge the assistance of Dr. Merlyn C. F. Lindert, consultant in gastroenterology at the hospital.

Quarter Century Diabetics

Diabetic patients who have survived without degenerative sequelae after many years of careful treatment receive an award called the Quarter Century Victory Medal. It was designed in 1947 by Amelia Peabody for the Diabetic Fund of the Boston Safe Deposit and Trust Company. To date, 90 such medals have been distributed to patients whose diabetes is of 25 or more years' duration. These patients show no albuminuria, evidence of hemorrhages, exudate, or cataracts. Their arteries are free from calcification as disclosed by x-ray examinations of the chest, abdominal aorta, pelvic arteries, and the lower legs. Howard F. Root, M.D. Treatment and Control of Diabetes Mellitus. GP. May 1961.





Cook County Hospital

Chronic Abdominal Pain in Childhood

Moderator: ROBERT J. BAKER, M.D.
Associate Director, Department of Surgical
Education, Cook County Hospital
Discussants: WILLIS J. POTTS, M.D.
Professor of Surgery, Northwestern University
Medical School; Surgical Consultant (Emeritus), Children's Memorial Hospital
JOSEPH GREENGARD, M.D.
Director, Department of Pediatric Education
Cook County Hospital

DR. ROBERT J. BAKER: This conference deals with a clinical problem which has, at some time, vexed every physician responsible for the care of children. We are primarily concerned today with the presence of a subjective symptom of pain, the reason for which is not readily apparent on workup.

Because of the highly complex emotional circumstances that make up the child's world, it is frequently necessary to assess symptoms such as this one with a highly critical attitude. On the other hand, many organic lesions, amenable to treatment, evade the light shed by x-ray and other studies, and the assumption that a negative physical and laboratory examination means absence of disease is frequently a hasty one.

Considerable clinical experience and acumen are essential to the solution of this type of

problem, and we have called upon two highly skilled clinicians with slightly different view-points for help. As everyone in this amphitheater knows, Dr. Willis J. Potts is one of the most distinguished surgeons in the world. As a pediatric surgeon, he has no peer, and his pioneering steps in the fields of cardiovascular and general pediatric surgery are well known. More than that, he is widely known as a superb surgical diagnostician; we are honored and delighted to have him here today.

Our second discussant is Dr. Joseph Greengard, director of the department of pediatric education here at Cook County Hospital, who is known as an experienced clinician and dedicated teacher. Dr. Greengard has practiced as well as taught pediatrics for many years, and we know that his experience in this particular problem will be a great help to us.

Case 1

DR. MARSHALL SPECTOR: (pediatric resident): This 9 year old Negro female was admitted to the medical division of the Cook County Children's Hospital with the chief complaint of intermittent pain in the right lower quadrant and right flank for about a year. About half of these episodes were accompanied by low grade fever; some were described as "cramp-

for February, 1962

ing," causing the child to double up, and these recurred at one to three week intervals. The episode immediately prior to admission had lasted longer than usual and was more severe. Three days before admission this child vomited following breakfast, and the pain became worse.

The past history was unremarkable. The mother said the child was well mannered and "easy going," as was a younger sister. No specific sibling friction was elicited by questioning the parents.

On physical examination the temperature was 99.2 F. rectally, pulse 108 per minute, respirations 20 per minute. There was tenderness in the right flank on deep palpation, as well as in the right lower quadrant. Bowel sounds were normal, and no costovertebral angle tenderness was elicited.

On the day following admission, a tubular mass was palpated in the right lower quandrant; it shifted toward the left with position change. Subsequently, the mass, always ill-defined, was felt in the right upper quadrant, and then it disappeared.

Laboratory work up included a normal hemogram, sickle cell preparation, stool cultures, and throat cultures. Blood chemistry disclosed a blood urea nitrogen of 14 mg./100 ml., calcium 10.7 mg. per 100 ml., and phosphorus 5.7 mg./100 ml. Gastrointestinal studies with barium, a cholecystogram, and an intravenous pyelogram were normal.

The child was discharged free of pain and asymptomatic on the twelfth hospital day, only to be readmitted two weeks later with right lower quadrant abdominal pain, nausea, and vomiting accompanied by mild left calf tenderness.

Dr. Baker: I might mention that investigation of this child was extremely thorough during both hospitalizations. The x-rays included numerous oblique and lateral views in upper and lower gastrointestinal series, and there was no evidence of mass or other extrinsic pathology at any time.

Dr. Greengard and his staff worked this patient up as far as they thought feasible; we will ask Dr. Potts for his comments on this patient, and especially if any further workup is indicated.

DR. WILLIS J. POTTS: What was the diagnosis on the chart?

Dr. Baker: The diagnosis was deferred, I believe.

DR. POTTS: It is pleasant to be here again because this amphitheatre is crowded with memories. Dr. Kellogg Speed gave a course in fractures here many years ago, and, because of Pott's fracture, mine was the only name he could remember; so I was asked all the questions.

Well, now, let's look at this child. What's the matter with her? I will stick my neck out and make one diagnosis: chronic intussusception. Will you agree with that?

Dr. Joseph Greengard: Yes.

Dr. Potts: I make this diagnosis because this is an absolute parallel to several cases I have seen. Unfortunately, one case may make too great an impression so that one is apt to keep bringing it up. I had a 6 year old boy who had exactly this story, and there was a tremendous dispute between members of the resident medical, surgical, and attending staffs. One would feel a mass, and then another examiner would examine the abdomen and say, "There's no mass in the abdomen." So they labeled this "tumor" a phantom mass. There was a very great to-do about the phantom mass, words which have to be pronounced slowly. At any rate, we operated upon this child and found nothing because the intussusception had reduced itself. We took out the appendix. His pain has not recurred for a couple of years, so probably he was cured.

Have you operated on this child?

DR. BAKER: No. We are waiting for you to tell us where to operate.

DR. Potts: If the child comes back again, you have to do something. Would you fix the cecum with stitches in the abdominal wall, Dr. Lichtenstein?

Dr. Manuel Lichtenstein, chairman, department of surgery: No; I would leave it alone.

DR. Ports: That is what we did. We just left it alone and took out the appendix.

Now, I suppose you want me to spend a few minutes talking about abdominal pain. A baby does not complain of pain. I don't think they have a lot of stomach-ache. I am deceived many times by pain in the abdomen in infants.

Here is typical case that comes to mind. An infant was transferred from another hospital and obviously had something the matter. It cried and fussed, and there was something ill-defined in the right side of the abdomen; but when one pressed on this questionable mass, the baby did not cry. The child was vomiting some bile, was distended, and looked sick. We diagnosed intestinal obstruction, and operated upon the child. Another point, this child I mention had no fever. He had one finding that was a clue we overlooked — a white blood cell count of over 25,000. At operation we found a lemon-size abscess and a tiny perforation of the bowel.

One can be confused easily in these cases: There is no pain, relatively few symptoms, no fever, and no real guide except the white count.

It should be noted that in children with fibrocystic disease there is a tendency for incomplete obstruction to occur in the ileum. Before the child has had too much trouble with cough and respiratory infection to make one suspicious of fibrocystic disease, partial obstruction may occur. The first time I saw this condition I did not realize its significance. One of the early findings of fibrocystic disease, although rare, is stenosis of the ileum. It is chronic; the baby is a poor feeder, whines, fusses, vomits, and finally vomits bile-stained material. At this point you know something is the matter. It is not easy to get evidence on upper or lower gastrointestinal study until obstruction is almost complete.

Children with duodenal stenosis have chronic pain that comes and goes. Sometimes, if the stenosis is mild, they get along all right for a time. They have ill-defined stomach-ache, colic, and do not seem quite right. Those children are apt to have a diaphragm with a hole in it in the duodenum. The outstanding characteristic is that they will vomit some bile upon occasion, and then get well spontaneously. I think behind this diaphragm a little rough material collects, temporarily obstructing the opening, and then it goes through. One of the most fascinating cases was a 6 month old child who had such symptoms. Finally, over a short period of time, he showed signs of complete obstruction. He was operated upon and had

duodenal stenosis but not very marked; he had swallowed a button. The only place fluid could go was through the holes of the button. Resection of the diaphragm from the opened duodenum cured the child.

Incidentally, it is worth mentioning here that in children with esophageal stenosis a foreign body may cause complete obstruction. A youngster may have very little trouble swallowing, but all of a sudden he has a lot; the partial esophageal stenosis catches a foreign body that makes obstruction complete.

I am glad that Dr. Baker mentioned the intravenous pyelogram. You must remember one fact which I consider exceedingly important: When a child comes in with diffuse pain in the abdomen which does not fit any picture, and the pain is anywhere between the knees and the chin, get an intravenous pyelogram. It is fantastic to see how many children are running around, a little weak and pale, who don't eat well and are cross; finally, somebody takes out the appendix. They don't improve and later are found to have a stricture of some portion of the urinary tract. Do obtain an intravenous pyelogram. The stricture may be a valve at the bladder opening, or there may be a stricture at the uretero-bladder junction. You will often find a ureter that is dilated and a kidney that is hydronephrotic. Fortunately, when it is limited to one side, the child can part with one kidney and live a normal life. Whenever there is diffuse pain in the abdomen of chronic nature, do not wait - get an intravenous pyelogram.

Is there such a thing as chronic appendicitis? When I was in medical school, there were some very dictatorial professors who taught us about chronic appendicitis and said unequivocally that there is no such thing as chronic appendicitis. So I started in practice with the teaching that chronic appendicitis was a condition diagnosed by a doctor for economic reasons. Shortly afterward, I saw a child 7 years old with recurring abdominal pain. He was sent home from school because he had a stomachache, and the mother said that this happened frequently. I examined him. He had some tenderness, his temperature was 99 F., and his white count was normal. I remembered that

there was no such thing as chronic appendicitis and put him on a mild diet and suggested a hot water bottle on his abdomen. He improved and went back to school. Before the mother left my office she said to me, "Do you think this is appendicitis?" To this I replied, "There is no such thing as chronic appendicitis." Two months later he was sent home from school, had pain in the abdomen, did not feel good, and vomited. His temperature was now way up to 99.2 F., the white count 8,000. The mother looked at me, I looked at her, and I said that this time I thought her child had appendicitis. Then I crossed myself up, because I took out his appendix and found a huge fecalith. This child did not have acute appendicitis but true chronic appendicitis.

Once in a while fecaliths are seen on x-ray, but I had not ordered an x-ray. The appendix was somewhat enlarged and the wall was thickened. That boy changed from a puny, whiny kid who picked at his food into a normal youngster. He gained 20 pounds. He played vigorously. His whole personality changed. Was that because his appendix was taken out? I don't know, but it seems likely. That was the beginning of my education in that condition.

I have since seen a few cases of chronic appendicitis. When everything else, especially the urinary tract, and the whole gastrointestinal tract, is normal but the tenderness persists, I don't think it is such a tragedy to take out the appendix. Here is what may happen to a child with attacks of abdominal pain. He goes to camp or goes to college or takes a trip and has another mild attack. What to do? Some doctor up in the north woods or in Mexico takes out the appendix while the parents are in a tizzy about who is operating and what is going on. So I say, once in a while, or twice in a while, that you are justified in removing the appendix, in cases of chronic abdominal pain, especially if the pain stays in one spot, but only after you have eliminated every other possible cause for the pain.

DR. BAKER: There are some problems that come to mind. Is there any way you can select which child needs his appendix removed on the basis of pain?

Dr. Potts: I simply don't think you can tell.

I don't know of any magic way to diagnose chronic appendicitis.

Dr. Greengard: I have had three carbon copies of your case.

Dr. Potts: I think everyone accumulates a few.

Dr. Greengard: However, if one does advise appendectomy and the child comes back with the same pain pattern, one is in trouble; and I have had that experience too.

DR. Potts: I think the older you get, the more mellow you become. You have made many mistakes, but in a case like this you can admit to the parents that you are not sure whether or not it is chronic appendicitis, but you would advise taking the appendix out. If the pain continues afterwards and you have eliminated everything else, at least you need not worry about appendicitis.

DR. BAKER: Dr. Greengard, would you comment on this case in regard to the workup?

DR. GREENGARD: First let me say that it is a pleasure to listen to Dr. Potts. He and Dr. Lichtenstein and I go back to the same era in this auditorium, and it is a great pleasure to be here with him.

From the pediatrician's point of view, this subject of chronic or recurring abdominal pain is different from the pain the surgeon is concerned with, because the surgeon ordinarily will see the patient after he has filtered through several other doctors; consequently, when the patient gets to the surgeon, he is more likely to have some true organic pathology. I think others will agree with me that the pediatrician probably meets this problem of abdominal pain in children more often than almost any other problem in his office practice. To the practicing pediatrician - and I was one for 30 years this is one of the most frustrating, annoying and irritating problems you can imagine. I would guess that in my experience perhaps 10 per cent of the infants who would come in with chronic, recurrent abdominal pain would eventually be found to have some real organic pathology or some functional pathology; but the vast majority of these youngsters had nothing one could put a finger on. At the same time, as Dr. Potts has indicated, the problem as it presents itself does not excuse you from

a comprehensive, complete workup. He has pointed out the genitourinary tract as an area that must be excluded as a source of pathology. I would emphatically reiterate what he has said: Never be timid about getting an intravenous pyelogram on your patients. Some doctors think they do not like to spend their patient's money, but it is much better to do that than to save the money and find that something has been overlooked.

The conditions listed as possible causes of the pain (Table 1) are some of the many diagnoses that must be considered. In this first patient Dr. Potts spoke about chronic intussusception, and I think that is a good possibility. I have had several such experiences in private practice. They are extremely difficult. The two youngsters I saw had made the rounds of several other doctors. It has been my impression that some of these recurrent or chronic cases of intussusception are ileoileal rather than ileocolic; would you agree?

Dr. Potts: I have seen too few to comment on that.

DR. GREENGARD: As to the management of this child, I would like to ask you: If somebody has felt a mass, even though it seems to be evanescent, would you consider it a good indication for exploration? Would that influence you?

Dr. Ports: If I felt it myself, yes. But if somebody else says a mass is there and you don't feel it, I think you can be stubborn.

DR. GREENGARD: Of the other intraabdominal conditions, what about hernia as the source of chronic abdominal pain? Would you accept that?

DR. Potts: In girls, yes; in boys, very rarely. Girls, and especially infants, often have an ovary that is in the inguinal canal. It is very hard to tell an ovary from a hydrocele of the canal of Nuck, but an ovary may be incarcerated in the inguinal canal and cause symptoms. These children are apt to be colicky, take food poorly, and are fussy, probably because of some pull on the ovary. These hernias are usually of the sliding variety of ovary or tube or both. After hernia repair the symptoms disappear. I don't think there are many symptoms from inguinal hernia in boys.

Table 1 CAUSES OF CHRONIC OR RECURRENT ABDOMINAL PAIN IN CHILDREN

INTRAABDOMINAL CAUSES

Peptic ulcer or duodenitis

Cholecystitis Gastroenteritis Bacterial Viral Parasitic Chronic intussusception Chronic appendicitis Regional ileitis Ulcerative colitis Hepatitis, pancreatitis (subacute) Malabsorption syndromes Hirschsprung's disease Internal hernia Polyp, with intussusception Rectal prolapse Tumor

GENITOURINARY CAUSES
Obstruction of urinary tract
Pyelonephritis
Renal tumors
Ureterocele
Calculi
Polycystic kidney
Foreign body
Meatus ulcer
Torsion of testicle (usually acute)

INTRATHORACIC CAUSES
Pleuritis (pulmonary disease)
Pericarditis
Rheumatic fever (carditis)

SYSTEMIC DISEASE
Rheumatic fever
Schönlein-Henoch purpura

Allergy Blood dyscrasia (sickle-cell, leukemia, myeloma)

Cyclic vomiting Abdominal epilepsy Diabetes

Meningitis and poliomyelitis (ordinarily acute)

DR. GREENGARD: As to conditions in other areas, intrathoracic lesions are extremely important. Pericarditis, carditis, and rheumatic fever in general are often complicated situations as far as abdominal pain is concerned. They play a more prominent role in the acute cases of abdominal pain, and we here at County had, in the old days, 5 or 6 patients

who were operated upon with a diagnosis of acute appendicitis who later turned out to have acute rheumatic fever. The pain may not necessarily be referred pain. There is apparently a definite type of rheumatic peritonitis that will give symptoms and physical findings very closely simulating suppurative peritonitis, and 1 suppose the comment here would be that, if in doubt, it would be better to go in, because there is no reason why a child with rheumatic fever could not have a suppurative appendicitis too.

This business of referred pain is interesting. Sickle cell anemia, as you all know, can be a eonsiderable problem in this regard. Sometimes these children have acute, severe abdominal pain, and occasionally one is operated upon with the misdiagnosis of acute appendicitis. Cyclic vomiting and abdominal epilepsy are of importance, as they both represent a controversial situation. I believe that there is such a thing as eyclic vomiting. It is a difficult situation to deal with. Fortunately, these conditions are self-limiting, and almost all of them disappear as the patient approaches puberty. I had one case 5 or 6 years ago; the boy was 14 years old, and he showed considerable delay in development of the secondary sex eharacteristics. I thought I could attack it by giving him hormonal therapy. I gave him testosterone and anterior pituitary, and he developed some enlargement of the genitalia, picked up weight, and his symptoms of cyclic vomiting disappeared. As for abdominal epilepsy, I don't know. I have seen one or two situations where the diagnosis seemed acceptable, and we had a fully developed syndrome of abdominal pain and vomiting, followed by drowsiness, or even sleep, and electroeneephalographic changes. But I think it is a difficult diagnosis to make.

Dr. Potts: I don't know a thing about abdominal epilepsy. I shy away from it.

DR. BAKER: Dr. Potts, do you consider exploratory laparotomy the ultimate in workup, or do you think this is something that should be considered only with a definite diagnosis? Do you consider exploratory laparotomy a logical culmination of the workup when everything else is negative?

Dr. Ports: Occasionally, but I think rarely,

this can be the case. I think the child should have some definite symptoms. We explored a patient last week who had had bouts of pain in the abdomen and he had passed blood a couple of times; all examinations were negative. Finally, we explored, expecting to find a Meckel's diverticulum, but we found nothing. We are very hesitant, unless we ean put a finger on something, to do just an exploratory laparotomy.

DR. ROBERT J. FREEARK, director, department of sugical education: What incision would you use for this patient in whom you finally decided that the appendix was a reasonable bet? Are you going to look through a McBurney incision?

DR. Potts: If the symptoms are localized, do a simple appendectomy. If the findings are diffuse, or if there are signs of intestinal obstruction with vomiting or a history of blood in the stool, make a large ineision, usually vertical, though some surgeons like a transverse incision.

DR. FREEARK: Were most of the appendectomies that were the culmination of workup earried out through a McBurney incision?

Dr. Potts: Yes.

Dr. M. Borovsky: I remember a ease of a phantom tumor, an internal hernia with defect of the mesentery. Have you seen this?

Dr. Ports: Yes, that is possible. It presents an interesting problem. Usually those patients have a lot of stomach-ache.

Dr. Baker: In a child who has had intensive laboratory workup, goes home and sometime later has recurrence of symptoms, is it worth while to go all through the workup again? Or would you simply rely on the symptoms for further evaluation?

DR. Potts: Don't misinterpret this, but if the x-rays are done by the same person and if you are satisfied with his examination, no. If it has been done in another institution, you will have to do it again.

Dr. Greengard: I would agree not to repeat the workup.

DR. Ports: I would want some pediatrician to go over the child very carefully. I am always afraid in these eircumstanees that I will do an operation for a medical disease. That is a thing

you never get over. Do you know what I did once? I took out an appendix for rheumatic fever. That was 25 years ago and I'll never forget it. It was a classical case: fever, nausea, pain, vomiting. And let me remind you that whenever you see a child with diffuse abdominal pain who is really sick, it takes only a moment to put your hand behind his head and decide whether meningitis is present.

DR. FREEARK: How often is stool analysis helpful for ova and parasites?

DR. GREENGARD: Stool analysis is quite helpful, but it should be done by taking a swab from the rectum. Then the specimen is fresh, and it is more convenient than waiting for a stool.

Case 2

DR. JAMES LONG (resident): A 3½ year old white female was admitted to the pediatric surgical service of the Cook County Hospital with a history of vomiting greenish material and moderately severe, cramping, generalized abdominal pain of approximately 30 hours' duration. This child had had numerous episodes of a similar nature, usually characterized by a similar sudden onset of pain and emesis, and frequently accompanied by moderate fever and restlessness. The patient had been hospitalized on three previous occasions in another city and, after three to seven days of management, the mother was told that the child was well, although she understood the doctor to say the child was "neurotic." The last episode was thought to be related to the death of a twin sibling some 3 months prior to the first bout of abdominal pain, and coupled with the mother's oversolicitous attitude toward the child's eating habits. Upper and lower gastrointestinal x-ray studies had been performed during two of these hospitalizations, but these films were not available.

Physical examination revealed a well developed, well nourished child who did not appear acutely ill. Tempertaure was 99.4 F. rectally, pulse 120 per minute. The only positive physical finding was very mild generalized abdominal tenderness. Urinalysis and hemogram were normal as were the white count and the differential count.

The child was observed. A minor emesis with a small amount of blood noted on the second hospital day was preceded by an exacerbation of the abdominal pain of 2 hours' duration. Thereafter, the child was improved and asymptomatic throughout the period of hospital observation. Complete workup was undertaken.

DR. BAKER: I was responsible for this child's care and there was one factor that was not included in this protocol. At the time the pain increased, abdominal swelling was also noted, and on examination percussion revealed a dull note. After the pain subsided, the swelling also subsided and the abdomen was flat. Gastrointestinal workup was undertaken. Dr. Potts, you made a comment about what you thought this was. Would you elaborate on this before we show the x-rays?

DR. Potts: This is a classical picture of chronic malrotation of the bowel causing duodenal obstruction. It is a fairly characteristic picture with intermittent obstruction of the duodenum. I spoke of it a month ago. It is uncommon enough to be missed too frequently, but there was a classic example in our material of a child who was a poor feeder as an infant. This child was taken care of in our own hospital. He went from one formula to another. We thought of celiac disease because of intermittent bouts of vomiting, and then graduated to cyclic vomiting, and at 5 we diagnosed her as having vomiting nervosa. These attacks of pain would last a day or two, and she became very difficult to handle. Remember that children are the most affable creatures in the world. They do not fuss if they are not sick; and if they fuss, you had better be awfully sure of your diagnosis. The child is not old enough to have developed all the tricks that older people have. They live and have fun. When they are nervous and do not act right, probably something is the

Finally, this little girl, at the age of 7, vomited and vomited; this time x-rays were taken, and there was a large duodenal bubble. She was operated upon; because of the obstruction to the vessels in the part of the bowel which was covered by the congenital membrane, the veins were almost the size of a piece of chalk. All one had to do was cut this band of adhe-



FIGURE 1. PA view of the chest and abdomen shows two dilated loops of small bowel in the left upper quadrant and a large radio density in the projection of the middle and lower abdominal fields.

sions which obstructed the duodenum, and the child became an affectionate, lovable creature instead of a personality problem. We had another child 2 years of age, treated elsewhere, with attacks of vomiting and pain in the abdomen. Each time the thing got better, so it was treated conservatively. Finally, she came in and by 5 a.m. she had vomited herself hoarse, was dehydrated, and died within an hour from duodenal obstruction secondary to malrotation.

DR. BAKER: I am interested in your comments in this regard because this child's mother was very apologetic. She said the child was nervous and disturbed, but she still felt that she should be in the hospital because she was worse than before. I would like to say that Dr. Potts knows the diagnosis in this case and is intentionally avoiding it so as not to give it away. In all fairness we had the advantage of sceing this child distended and having hematemesis, and this had not been seen before. As soon as the acute symptoms subsided, workup was started and the following films were obtained.

Dr. Love: The heart and lungs were normal.

There are some distended loops of small bowel on this film (Fig. 1).

This is an interesting examination (Figs. 2 & 3). On study of the upper gastrointestinal tract, the stomach and the duodenum are normal. Past that area, in the proximal jejunum, there are multiple dilated loops of bowel and an abrupt termination, with an area that looks like compression of the bowel below; so we think it is a large mass causing pressure on the proximal small bowel. We could consider a cyst arising from the region of the ovary or a mesenteric cyst or teratoma from the region of the sacrum. I have seen, in adults, a huge dilated bladder do this. I think all these things should be considered. It did not seem to be in the region of the pancreas.

DR. BAKER: This child was operated upon and a cystic structure was removed from the mesentery and adjacent area of the proximal jejunum. Even at the time of surgery, the proximal jejunum and duodenum were dilated, showing evidence of chronic obstruction. This was, in fact, an upper small bowel obstruction secondary to a mesenteric mass.

A loop of jejunum was resected with the mass, and when this loop was opened, you could see the bloody content. What had happened was that the pressure of the mass against the loop of bowel had caused erosion with ulceration into the bowel; this mass would intermittently drain part of the fluid, and it would reform after the perforation into the bowel sealed off, so that cystoenteric fistula existed intermittently.

This case, we hope, demonstrated, as Dr. Potts pointed out, that children with abdominal pain and these other symptoms should not be assumed to be emotional or feeding problems. This was a small child of 3½ years. I talked to the mother 6 months later, and she said the difference was remarkable; the child ate better, had gained normally, and was totally normal in every regard.

Dr. Potts, this particular problem has not occurred here often. Do you see this—the individual labeled as a difficult emotional problem?

Dr. Potts: Yes.

Dr. Baker: What organ system is most fre-



FIGURE 2. AP view of the barium meal shows an elevation and distortion of the stomach and duodenum with incomplete obstruction of the proximal jejunum.



FIGURE 3. Lateral view of the barium meal shows elevation and distortion of the duodenum and proximal jejunum.

quently implicated?

DR. Potts: I would guess the genitourinary. I think it is in this area that the most commonly overlooked reasons for a child being sick and irritable and fussy and undernourished have occurred.

Dr. Baker: Have you seen a mesenteric cyst causing obstruction like this? It was defiinitely such a cyst.

Dr. Potts: No, nothing like this.

Dr. Greencard: I want to make myself perfectly clear where conditions such as cyclic vomiting, abdominal epilepsy, and other functional diagnoses are concerned. I am sure that such entities do exist; but where abdominal pain is concerned, I am in complete agreement with Dr. Potts, and I thought I indicated that no one has the right to make such a diagnosis without going through a complete and exhaustive workup to exclude all organic causes. We had an excellent illustration of that a year or two ago in a young girl who had evidence of a syndrome that imitated cyclic vomiting, which was the diagnosis. It was a case which presented for complete workup, and on x-ray she showed a duodenal ulcer. I want to leave you with the feeling that this is my view, and

any cases that present this picture must first be carefully worked up to exclude all other diseases or pathology in the abdomen and in the genitourinary tract.

DR. BAKER: I want to thank both Dr. Potts and Dr. Greengard for a most illuminating discussion.

POINTS TO BE REMEMBERED CHRONIC ABDOMINAL PAIN IN CHILDREN

- 1. Abdominal pain is one of the most common symptoms presenting in the pediatric age group, probably comparable to malaise in adults. This symptom, therefore, can be the prodromal one of practically any pediatric disease, medical or surgical.
- The history, just as in older patients, is of extreme importance but is very difficult to elicit at times and is derived entirely from the parents in patients under the age of three.
- 3. Analysis of the history of the pain revolves around the following details:
 - a. Site of pain visceral pain, in general, is central; parietal pain is more lateral.
 - b. Quality of pain colicky or cramping

- pain indicates impeded passage, e.g. through a hollow viscus.
- c. Timing of pain intermittent, continuous, etc.
- d. Radiation of pain charactertistic with given lesions, as ureteral pain radiating into the groin.
- e. Association with other symptoms abdominal pain may be only part of a complex picture, as pneumonia with diaphragmatic pleurisy.
- 4. Physical examination includes all routine procedures. The examiner must keep in mind that the child is ordinarily fearful of examination. Distraction with toys or conversation is usually helpful. The success of the examiner is directly proportional to the patience and thoroughness which he displays.
- 5. An essential part of the examination is the digital exploration of the anorectal canal. This should be the last procedure of all to avoid agitation of the child before it is necessary, and it should be done carefully, explaining the procedure to the child when feasible.
- 6. The most common abdominal surgical con-

- dition in childhood is acute appendicitis. This is much less common under the age of four, and when combined with those cases in which the appendix assumes an atypical location, the explanation for the high morbidity and mortality in these two groups lies in an insufficiently high index of suspicion.
- 7. The more common medical diseases simulating surgical conditions by virtue of presenting with abdominal pain are:
 - a. Acute gastroenteritis
 - b. "Colic" in infants and young children
 - c. Gastrointestinal allergy
 - d. Measles
 - e. Acute rheumatic fever
 - f. Poisonings, especially lead
 - g. Diabetic acidosis
 - h. Leukemia, lymphoma
- 8. One of the most commonly missed sources of chronic abdominal pain is that emanating from obstruction or inflammation of the genitourinary tract, especially in infants. An intravenous pyelogram with or without lower tract studies is most important in the workup for obscure pain.



According to the ISMS Constitution . . .

Section 2. Each councilor shall be organizer, peacemaker and censor for his district. He should visit the counties in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each county of his district to the Council and to the House of Delegates. The necessary traveling expenses incurred by such councilor in the line of the duties herein imposed, may be allowed by the Council upon presentation of a properly itemized statement.

Drugs During Pregnancy

An interesting phenomenon described in the recent literature is the occurrence of withdrawal symptoms in infants born to mothers addicted to narcotics. In such cases the mothers usually had had injections of the drug within a week of the delivery. The picture is a characteristic one: The infant is decidedly irritable, may be flushed, and has a high-pitched, constant, cere-

bral cry. Convulsions may occur. The mortality rate in such infants is definitely increased unless the condition is recognized and promptly treated. This diagnosis may be difficult because of attempts to conceal the addiction. Infants born to mothers addicted to alcohol may show milder symptoms suggesting a similar withdrawal syndrome. Douglas H. Sandberg, M.D. Drugs in Pregnancy, Their Effects on the Fetus and Newborn. California Med. May 1961.

The View Box

FRANZ GAMPL, M.D., Chicago

This female infant was born after a normal pregnancy and an uneventful delivery. At the time of her first feeding she developed cyanosis and regurgitated frequently.

What is your diagnosis?

- 1. Hyaline membrane disease
- 2. Meconium ileus
- 3. Atresia of the esophagus
- 4. Intestinal obstruction

(continued on page 157)



FIGURE 1. Chest radiograph made 7 hours after birth.

From the radiology department, Cook County Hospital

Surgery for Occlusive Process

This study of a large number of patients with a disease resulting from arteriosclerosis adds weight to the concept that the lesion causing cerebral arterial insufficiency, as well as the other syndromes of arterial insufficiency of arteriosclerotic origin, is frequently well localized with normal vessel both proximal and distal to the occlusion. Furthermore, the lesion in patients with cerebral arterial insufficiency is frequently located extracranially in the neck

or chest. These fortunate pathologic features of the disease permit application of technics directed toward the lesion itself which immediately restore normal pulsatile circulation. Either endarterectomy or bypass graft, proven effective in the treatment of similar lesions elsewhere, may be effectively applied according to conditions dictated by the location and extent of the occlusive process. E. Stanley Crawford, M.D., et al. Treatment of Stroke by Arterial Reconstructive Operation. South. M. J. May 1961.



MEDICINE in the OUT-OF-DOORS

Immunizations for the Venturesome

Julius M. Kowalski, M.D., Princeton

THE FAMILY UNIT is now more closely identified with outdoor activities than ever before. Traditionally, only men engaged in vigorous sports, often under adverse conditions, while women tended home tasks in comfort by the fireside. The image of the virile male has been altered in a snide way by a great national surge of families in boating interests and an overwhelming desire for camping. Most often these family efforts require planning, budgeting, and timing. Usual illnesses in the small fry are anticipated, but means are available to every family for effective protection from serious debilitating diseases. Though the immunological procedures under discussion are not inherent in the out-of-doors, two are seasonal and are capable of shattering the best-laid plans for a summer tour or fall hunting trip.

Poliomyelitis

Prior to 1955 many a parent hoped that the family physician could offer them some assurance against polio for the child who was leaving for summer camp or that the disease would not suddenly appear in the distant area they chose for a vacation, or in the vicinity of the local swimming pool. With devastating regularity, poliomyelitis skipped about the country striking now a metropolis and then a rural community, defying prediction, crippling, and killing. The U. S. Public Health Service reported almost 58,000 cases in the country for the year 1952, the last high-incidence year. In 1954 field trials were conducted with Salk vaccine, and in the following two years it was available

to the public. Gratifying results have been achieved despite the fact that 40 to 50 per cent of the population presently is unvaccinated or incompletely vaccinated. Citing Illinois State Bureau of Epidemiology figures as an example, in 1956 there were just under 2,000 polio cases reported with a decline to only 31 (sic) cases for 1961. In the entire nation there were slightly less than 1,300 cases in the year 1961—remarkable results, indeed, with Salk "killed" polio vaccine.

But a sizeable segment of the population has misgivings about the "best" kind of polio vaccine. People learned of the virtues of Sabin "live oral" vaccine as opposed to Salk vaccine.

The Illinois Department of Public Health issued its latest recommendations for poliomyelitis immunization in October, 1961, as follows:

- 1. Basic immunization against poliomyelitis shall consist of three doses of "killed" poliomyelitis vaccine 1.0 cc. each, spaced as follows: approximately one month between first and second doses and at least five months between second and third doses.
- 2. Basic immunization is recommended for individuals under the age of 40.
- 3. It appears desirable that a booster dose of "killed" poliomyelitis vaccine be given pre-seasonally to individuals who received their last injection of primary immunization a year previously, and at yearly intervals thereafter.

If every family followed these recommendations, then polio would be repressed to almost (continued on page 158)

The View Box—diagnosis and discussion (continued from page 155)

The clinical diagnosis of atresia of the esophagus was confirmed by the following radiographic findings:

1. Absence of the normal gas pattern in the



FIGURE 2. Enlargement of chest roentgenogram shows upper esophagus distended by air.

FIGURE 3. The site of atresia of the esophagus at the level of the bifurcation of the trachea is demonstrated by use of Lipiodol®.



stomach and the small intestines.

2. Distension of the upper half of the esophagus by air (Fig. 2).

3. Instillation of contrast medium in the atretic esophagus demonstrates the site of the atresia at the level of the bifurcation of the trachea (Fig. 3).

Discussion

The esophagus is formed by the posterior part of the endodermal tube, which, separated by a mesodermal septum, forms the trachea anteriorly.

A persistent communication between the two parts of the common anlage results in a tracheoesophageal fistula. The endodermal canal which forms the esophagus obliterates at an early stage of development. Failure of recanalization will result in atresia of the esophagus.

The clinical symptoms of cyanosis and regurgitation during feeding warrant immediate investigation for esophageal atresia or tracheoesophageal fistula. Esophageal atresia is combined with tracheo-esophageal fistula in 70-90 per cent of cases. The absence of intestinal gas is the most conspicuous finding. Air fills the stomach with the first breath of the infant and reaches the colon within the first two to five hours after birth. A normal gas pattern does, however, not exclude the presence of atresia of the esophagus if a tracheo- or broncho-esophageal fistula is coexisting. In these cases, air reaches the intestinal tract via the persistent opening between the trachea and the patent distal portion of the esophagus.

Examination of the intestinal tract with radiopaque media will complete the investigation and demonstrate any associated anomalies in the intestinal tract. It also serves to exclude other causes of deficient gas pattern in infancy, such as diarrhea, dehydration, poor respiratory effort, and adrenal insufficiency.

Treatment: Immediate surgical correction is lifesaving.

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Immunizations for the Venturesome (Continued from page 156)

the vanishing point.

Influenza

Influenza turns the most robust man into a quaking leaf, and when it strikes in a duck blind under darkening skies and falling temperatures or on a deer stand in a gusty, knifing wind, it will never be forgotten.

This disease has long been known as a cause of excess deaths; approximately 60,000 such deaths resulted from the Asian influenza epidemic in late 1957 and early 1958. An analysis of these mortality figures disclosed the vulnerable groups to be (1) persons in the age group of 65 or older, (2) individuals of any age group with certain chronic illnesses, and (3) pregnant women. Likewise, the complications arising from the disease are greater in the above groups. Outbreaks of the disease follow a cyclic pattern for each of the strains, but since some intervals are longer than others, overlapping results and the disease is always present to a greater or lesser degree.

Polyvalent influenza vaccine may be of value in preventing the disease, ameliorating it, or reducing complications if contracted. Though the studies on the subject vary, they disclose that after adequate immunization 60 to 75 per cent of persons are completely protected, and the remainder usually have a mild form of the illness. Where the innoculation program has been carried on for several years, absenteeism in industry has been reduced 50 per cent and complications greatly reduced, as shown by a study of the N. Y. Times personnel. The Armed Forces, many utility coroporations, major airlines, and other large industries have adopted regular influenza immunization programs.

The Surgeon General's Advisory Committee on Influenza recommends that the adult dose of polyvalent vaccine for initial immunization be 1.0 cc. administered subcutaneously to be followed by a similar injection approximately two months after the first. Persons who have been innoculated the previous year should receive a booster injection of 1.0 cc. each year thereafter to maintain immunity.

Influenza is in the ascendency through fall and winter with the onset of inclement weather.

so the ideal time to begin an immunization program is about September 1. However, it will be recalled that the Asian influenza epidemic began in the summer of 1957.

The vaccine is grown in chicken eggs, and therefore a small but significant danger exists for persons who are allergie to eggs or chicken. The Advisory Committee has advised against vaccination for persons who are unable to cat eggs or chicken because of food allergy or who previously have had a definite allergic reaction, whether urticarial, asthmatic, or anaphylactic to innoculation of any egg vaccine. The anticipated side reactions (febrile responses, malaise, local tenderness at the injection site or rhinorrhea) occur in the order of 2 to 10 per cent and seldom persist after the first 24 hours—a small sacrifice as compared to the acute illness and attendant convalescences.

Tetanus

This most serious disease can be prevented by adequate immunization and periodic booster injections. A recent study of 123 treated cases² discloses that almost 50 per cent of these patients could recall no history of a wound or injury, or if they did remember the episode, it was so seemingly trivial that it was disregarded by them or the first physician who saw it. The tetamis rate in the U.S. Army during World War 1 was 13 per 100,000 injuries. No immunizations were available then. In dramatic contrast, during World War II when all military personnel were innoculated, the tetanus rate fell to 0.44 per 100,000 injuries (only 12 eases in over 2,500,000 injuries). And the latter confliet was primarily a "burn" war, giving rise to injuries in which the incidence of tetanns is increased. On the other hand, the Axis military forces suffered appreciably because no immunizations were given, and it was widespread in the civilian population where fighting was intense or prolonged. This is a most striking record and an emphatic claim for the efficacy of adequate tetanus immunization.

The spores of Clostridium tetaui remain viable for incredibly long periods and under adverse conditions of heat and cold. The assumption should be held that they are present everywhere all the time—in and about our (continued on page 161)



FIGURE 1. Liver at autopsy.

Prophylactic Intermittent Antibiotic Therapy for Recurrent Cholangitis

Eliot E. Foltz, M.D., Winnetka

In These Days when the medical journals are replete with articles warning physicians to refrain from the empirical use of antibiotics, it is with some trepidation that the following case is presented, for it suggests that recurrent cholangitis may be terminated, or at least controlled, by the discreet, intermittent use of antibiotics.

Case History

The patient was first seen in 1947, when she was 72 years old. She gave the history and had the findings of a cholecystitis with cholelithiasis and a low grade obstructive jaundice. In July, 1947, she was admitted to Evanston Hospital for study and subsequent surgery. The gall-bladder was removed, and showed a chronic cholecystitis and cholelithiasis. The common bile duct was markedly enlarged. It contained brown bile, dirty debris, and granular material. Three stones were removed from the common duct, all of which measured 8 to 10 mm. in the largest diameter. There was considerable "mudlike" material debris. There were repeated

scoopings, washings, and probings. Probes of 3 and 4 mm. were passed through the ampulla of Vater. After the common duct was thoroughly explored and irrigated, a T-tube was placed in it and remained in place about six weeks.

In September, 1948, she had a sudden onset of severe, steady, noncramping epigastric pain associated with nausea and vomiting that lasted three days. She was then started on ketocholanic acid therapy, which she was to continue taking for the rest of her life. This pain syndrome, which soon began to radiate to the back and to be accompanied by much perspiration, continued intermittently for the next four years.

In June, 1952, she was hospitalized with jaundice thought to be due to sludge or a stone in the common bile duct. During her weeklong hospitalization the total serum bilirubin dropped from 2.71 to 0.81 mg. per 100 ml., and she was discharged on a low-fat diet and a vitamin supplement, as well as ampules of amyl nitrite. It was necessary to re-hospitalize her in July of 1952 because of recurrent jaundice. A consulting surgeon advised a choledochostomy. At surgery on July 15, the common bile duct was opened and was found filled with yellow-brown calcareous material. There were stones above and below the common bile duct opening. After repeated irrigations, scoopings, and probings — checked at three different times

Department of medicine, The Evanston Hospital

by cholangiograms on the operating table — the duct seemed completely clear. A T-tube was inserted and the operation terminated. This T-tube was left in place about six weeks.

On August 1, examination of the drainage from the T-tube revealed amorphous debris, epithelial cells, and baeteria, but no crystals. The organisms grown out in culture were *Pseudomonas aeroginosa* and enterococci. Because in the past the patient had tended to have a mild leukocytosis and fever with the episodes of pain, she was put on chlortetracycline, 250 mg. four times daily for two weeks, empirically. On August 11, a T-tube cholangiogram was normal.

After this the patient complained of no distress until March, 1954, when she began to have five-minute episodes of epigastric distress daily. These would occur at no particular time of day. By April the distress had become severe pain and was accompanied by much nausea, vomiting, and some diarrhea. There were no signs of clinical jaundice. Total serum bilirubin varied from 0.74 to 1.12 mg. per ml. It was felt that there was probably more sludge in the common bile duct, and a laparotomy was again done on May 15. This time the common duct was not dilated, and a diverticulum of the duodenum was observed. It was located in such a manner that "it was apparent that mechanical distention of the duodenal diverticulum might well exert pressure on either the pancreatic duct or conceivably the ampullary region. With the duodenum open, the diverticulum was excised. A catheter was placed in the opening in the common bile duct and the duct extensively irrigated with saline solution. A soft, puttylike stone 2 mm. in diameter was floated out. An operative cholangiogram was interpreted as not showing any sign attributable to remaining stones within the duct." Again, a T-tube was placed in the common bile duct. She was discharged from the hospital on a low-fat diet and ox bile extract (Ketochol®).

Cultures of the T-tube bile revealed a heavy growth of Aerobacter aerogenes, a light growth of Escherichia coli and a moderate growth of diphtheroids, found to be moderately sensitive to tetracycline. The T-tube was left in place until it came out in January, 1955. During this period, the patient was symptom-free.

Five weeks after the T-tube came out, she

developed all of her old symptoms of a block in the common duct. At this time, it was decided to put her on tetracycline, 250 mg. four times daily. After five days of tetracycline therapy she had no further immediate symptoms. It was therefore felt that possibly the antibiotic had averted another obstruction of the common bile duct.

It was recalled that in 1952, following surgery and a two-week course of chlortetracycline, she had remained symptom-free for 19 months, but reoperation had eventually been necessary. In an attempt to forestall future recurrences that might again necessitate surgery, intermittent tetracycline therapy was tried. I arbitrarily decided that once every five weeks she should take 250 mg. four times a day for five consecutive days. This program she followed until her death, due to massive myocardial infarction, on Sept. 30, 1959.

During the four years and seven months she was on this program, she had no sign or symptom of common bile duct obstruction.

At autopsy the common bile duct was very markedly dilated with a maximum circumference of 5 cm. (Fig. 1). The intrahepatic portions of the major right and left hepatic bile ducts were also dilated. The common bile duct was fibrosed but showed very little evidence of inflammation. Smears of bile from the common duct showed some gram-negative rods. Cultures yielded a heavy growth of Aerobacter aerogenes and Escherichia coli. No biliary cirrhosis was present, but some interstitial fibrosis and adiposity of the pancreas were present, probably representing a healed, chronic pancreatitis.

Discussion

The bacteria cultured from the T-tube were most probably in the biliary system due to reflux from the duodenum, and were almost certainly etiologically related to the cholangitis with its resultant sludge. That after autopsy similar organisms were cultured from the common bile duct in the presence of grossly normal bile suggests these may have represented intestinal organisms which availed themselves of the opportunity to enter the common duct after death.

The duodenal diverticulum was not an im-

portant factor in the obstruction of this common bile duct, because after its removal, symptoms of obstruction recurred with consequent dilatation; and the duct had been found normal in size at surgery in 1954.

Of course, the apparently good results in this one case do not prove the efficacy of this treatment. However, it is of interest to note that over eight and a half years the longest period of freedom from pain was 19 months, and that was immediately following surgical cleansing of the duct augmented by two weeks of chlortetracycline therapy. After the third and last laparotomy the patient had an episode of pain characteristic of her former obstructive episodes, which prompted the inauguration of intermittent tetracycline therapy. Subsequently, I learned that Zaslow^{1,2} and Pulaski³ found that tetracycline appeared to be the drug of choice for infections of the biliary system.

Intermittent tetracycline therapy was continued until her death following a massive myocardial infarction, four years and seven months later. During this entire period, she remained

completely free from biliary tract pain, and at autopsy her bile was thin, golden, and free from debris. It is possible that the tetracycline might have been given less frequently, in smaller doses, or for shorter periods with equally good results.

Summary

Cholangitis, which had recurred many times in an eight and a half year period and had made necessary three operations on this patient between her seventy-second and eightieth years, stopped for the remainder of her life (four and a half years), following the institution of intermittent tetracycline therapy.

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Immunizations for the Venturesome

(continued from page 158)

homes, places of work, on all our clothing, and in all soils. The organism requires an anaerobic environment in the presence of devitalized tissue for growth. These conditions pertain most frequently in the typical puncture wound, deep laceration, or burn. Once the disease process begins and paralysis develops, it is extremely difficult to reverse the process, and often all attempts to halt it are futile. Neglected cases often end in 80 per cent mortality, and presently the disease is most prevalent among narcotic addicts of the large metropolitan areas who regularly inject themselves with nonsterile needles and syringes. The skin trauma in addicts is not, for the most part, the deep wound that a fisherman might encounter from having a hook imbedded in his hand or that a picnicker might receive from barbed wire or a nail.

Adequate immunization against tetanus is achieved after at least three injections separated by intervals of three to six weeks. Currently, for adults it is combined with diphtheria

toxoid — a bonus. After this primary series, a reinforcing dose 6 to 12 months after the last injection is given to complete the basic immunization. Booster doses should be given every 4 years thereafter to maintain a high level of immunity or whenever an injury occurs.

Everyone is in need of the above immunizations — be he an armchair traveler with a National Geographic in his lap, or one who crawls wearily at night into a damp sleeping bag beneath the pines.

The daily press is filled with pros and cons concerning the horrible effects of an atomic war, fall-out shelters, and all the rest. Certainly these problems demand solution, but let us now protect ourselves from ever-present diseases which surely would be more widespread after a holocaust, man-made or an act of God. Not everyone will be at ground zero nor showered by the fall-out if the egg is detonated.

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Development of a Cardiovascular Surgical Research Laboratory in a Small Private Hospital

LAWRENCE G. KHEDROO, M.D.,¹ PHILIP A. CASELLA, M.D.,¹ JOHN MOSES, M.D.,² and ALI ASGAR, M.D.,² Chicago

PROCRESS IN THE SURGICAL treatment of congenital, neoplastic, and degenerative disease has necessitated re-evaluation and relearning of fundamental physiologic principles and knowledge of newer surgical techniques. The ability to develop these programs is commensurate with the degree of knowledgeable orientation of the medical staff. At Alexian Brothers Hospital a surgical research laboratory has been developed for application of the heart-lung machine as related to open-heart surgery (canine). For similar institutions interested in this type of research, the following report describes objectives of our experimentation, organization of the research team and its project, and development of the physical aspects of the research laboratory and equipment.

Prior to the actual organization of personnel and the purchase of equipment, certain prerequisites are desirable: (a) a dedicated group of surgeons, (b) an informed and interested medical staff, (c) a benevolent, progressive hospital administration, (d) a well-organized research problem geared to the facilities of the hospital and the ability of the projected research team, and (e) financial aid in the form of grants, donations, and personal gifts. Should one of these prerequisites be unattainable, it is far better to temporarily postpone the program; lack of it will doom the project to failure in spite of much initial groundwork.

Objectives of Research

The objectives of a surgical research project may be one or several. In this instance the project was considered important as a correlative technical training program in which surgical residents could participate, and as a stimulus to the younger staff surgeons to continue or initiate research into basic surgical physiology. In addition, the project served as a method to develop essential skills in cardiac catheterization and angiocardiography in conjunction with the departments of biochemistry and roentgenology.

Personnel

The organization of the technical and non-technical personnel was closely related to equipment and canine, pharmaceutical, and medical supply procurement. Additional problems were transport of donor (dog) blood, canine care and disposal, prevention of cross-contamination, and accurate recording of scientific data.

The research team consisted of two surgeons, one internist, one nurse-anesthetist, one surgical instrument nurse, and the surgical residents and student nurses who rotated on an assignment basis during their tenure at our institution. Collateral assistance was obtained from departmental personnel: the chemistry department for serological and whole-blood chemical tests, the pathology department for microscopic section preparations, and the maintenance section for laboratory sanitation and animal care.

Personnel of the maintenance section were chosen for their loyalty, understanding, and un-

¹Attending surgeon

²Resident in general surgery

From the Surgical Research Laboratory, Alexian Brothers Hospital, Chicago

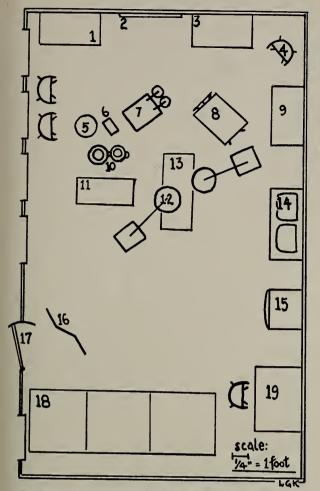


FIGURE 1. Floor plan of experimental surgical laboratory, Alexian Brothers Hospital, Chicago.

communicability. It should be understood that the team leader should choose the personnel tentatively, having in mind the ever-present possibility of personality differences developing as well as lack of interest as the surgical project proceeds. Only those who have done experimentation and research can appreciate the long periods that lead to consistently depressive results until some seemingly magical breakthrough stimulates the research worker. This must be understood by all personnel, for when the novelty wears off, interest and application must be maintained at a high level by added effort.

Several aspects which facilitated teamwork may be enumerated. The team leader outlined the project to all team members and held informal meetings to explain technical changes or new objectives. Each member was assigned a primary and a secondary job category, because during experiments switching of assignments



FIGURE 2. Photograph of the laboratory shows the equipment assembled and ready to be used.

LEGEND FOR FLOOR PLAN OF EXPERIMENTAL SURGICAL LABORATORY

1.	Clothes locker	11.	Pumps (arterial,
2.	Blackboard		venous, coronary
3.	Instrument cabinet		sinus flow)
4.	Chair	12.	Surgical lights
5.	Oxygen tank	13.	Canine operating
6.	Suction pump		table
7.	Anesthesia	14.	Scrub sinks
	apparatus	15.	Refrigerator
8.	Surgical	16.	Screen
	instrument stand	17.	Entrance
9.	Accessory	18.	Dog pens
	instrument table	19.	Desk

was found necessary. It was helpful to have alternate team members who could substitute should sickness or emergency duty prevent the presence of a permanent team member. Since the equipment of the heart-lung machine required practice and time to assemble, team members took turns in the assembling process; this created an added mutual interest and increased efficiency. One team member was assigned to keep accurate and complete records of all experiments to provide for proper

Oxygenator

canine subject died inadvertently, a post-mortem examination was done; only in this manner was it possible to correct some technical surgical errors.

Physical Aspects of the Laboratory

With progressive design changes in heartlung apparatus, a particular unit may shortly become outdated; this is not an important factor. In cardiovascular research the actual training of a team in the fundamentals of cardiac by-pass procedure is the most important objec-

TABLE 1. Complete Surgical Instrument Set-Up For Thoracotomy (Atriatomy, Ventriculotomy, Pulmonary Arteriotomy).

Pump-oxygenator (Julian-Lopez-Belio model), laboratory model, 2200 cc. per min. max. flow capacity 1 TM 2 Sigma-motor (arterio-venous) pump (110 V/220 V, 60 cycle motor)

TM 4 coronary sinus return pump (110 V., 60 cycle motor)

Fixed speed respiration pump (Harvard, #606) Accessory stainless steel fittings (tubing connectors) Mayon Flexible Transparent Surgical Tubing Blood filters

Gum Latex Tubing

Dow Corning Viscose Anti-Foam Spray

Bardic venous circuit catheters

Manometer for internal mammary artery (cannulated) pressure recording

TABLE 2. PHARMACEUTICALS NEEDED IN A CARDIOVASCULAR RESEARCH LABORATORY.

Penicillin: (conc. 600,000/cc., amp.) Heparin: (conc. 50 mg./cc., amp.)

Protamine sulfate: (conc. 100 mg./cc., amp.)

Adrenalin: (conc. 1-1000, amp.)
Procaine: (conc. 200 mg./cc., amp.)
Mecholyl: (conc. 25 mg./cc., amp.)

Potassium citrate: (conc. 250 mg./cc., amp.) Acetylcholine: (conc. 100 mg./cc., amp.)

Physiological saline: (conc. 0.85%)

Zepharin: (conc. 1-1000) Ethyl alcohol: (conc. 95%)

tive. Technical improvements and more efficient surgical manipulations can be expeditiously mastered as experience grows.

The technical equipment, pharmaceuticals, and medical supplies are listed in tables 1 and 2. Figure 1 outlines the floor plan of the laboratory. Figure 2 shows the equipment prepared and ready to be used.

Canine procurement was accomplished from

a nearby medical school research laboratory; all dogs had been vaccinated for rabies, dewormed, and treated with anti-flea solution. The dogs were obtained several days in advance of the experimental procedure to enable the preliminary application of a battery of serological tests that were a part of our particular research project.

Donor blood was obtained on the morning of the experiment. The blood was preserved in a heparin-glucose solution (30 mg. heparin in 30 cc. 5% glucosin in water for each 1,000 cc. of donor blood) and kept in a cooler. It was used in the oxygenator system always within a six-hour period. Several methods were used to prevent and reduce laboratory-to-hospital bacterial cross-contamination. All cloth material such as caps, gowns, masks, and towels was dyed pink (in contrast to the regular surgical aquamarine) and laundered separately. All surgical instruments were marked with a painted red stripe, indicating origin from the laboratory and need for separate sterilization. The laboratory floor, walls, and permanent fixtures were kept clean and washed at regular intervals with strong detergents. After each experiment, personnel required to return to duty in the hospital undertook a complete change of outer garments and an efficient cleansing of exposed parts of the body.

This surgical research laboratory has been in operation about two years. It is fulfilling its objectives and at the same time allows this small private hospital to serve the community through its teaching and research programs.

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We wish to acknowledge the invaluable assistance of G. Ermatinger, R.N. (anesth.) and J. Blanchette, R.N.

KEEP THESE DATES OPEN:

A.M.A. Annual Meeting Chicago, June 24-28, 1962

The Food Protection Committee of the National Research Council

JAMES R. WILSON, M.D., Evanston

IF IT WERE POSSIBLE to feed 170 million Americans, using only the techniques of production and preservation in common use in the year 1900, then there might be no need for a food protection committee. But, since continuous technologic changes involving intentional or incidental additions of chemicals to foods have been necessary to maintain the abundant food supply essential to a strong nation, the Food Protection Committee is also essential.

Research organizations, both public and industrial, constantly search for and frequently discover chemicals useful in food production or processing. Farmers combat in every available way those factors that threaten the yields and quality of their produce. They look for effective chemical means of overcoming soil deficiencies and of controlling pests and diseases of plants and animals. Food technologists from the universities, government laboratories, and industry seek ways of enhancing or stabilizing the nutrient value of processed foods, of improving and maintaining their attractiveness, and of adding diversity and convenience. Packaging manufacturers endeavor constantly to improve their products or find new uses for them.

It is a major responsibility of all of these groups to provide foods of such kinds and quality necessary to maintain health and productivity of the people. To permit the food producers, processors, and packagers to handle their share of the responsibility, they must be allowed to avail themselves of all useful technologic and scientific advances. This is the American way of doing things. Judgment and wise counsel, however, are necessary to prevent premature, unwarranted, or possibly dangerous application of unfolding technological and scientific information.

The Food Protection Committee was formed

Lecturer, department of nutrition, food science and technology, Massachusetts Institute of Technology to give such counsel, its primary purpose being "to provide critical evaluation of information concerning the use of chemical additives in foods for the counsel and encouragement of the food industry and as guidance for public agencies."

In 1950 the National Research Council established the Food Protection Committee as a committee of the Food and Nutrition Board. Financial support through the National Research Council comes from industry, commercial laboratories and private gifts to provide for a secretarial staff and committee meetings.

Members of the Food Protection Committee are scientists of recognized integrity and competence in the fields of medicine, toxicology, food technology, and nutrition. They give generously of their time without remuneration.

Useful reports* of this committee include:

Safe Use of Chemical Additives in Foods. (1952) Annotated Bibliography of Analytical Methods for Pesticides. (1952)

Principles and Procedures for Estimating the Safety of Intentional Chemical Additives in Foods. (1954)

Safe Use of Pesticides in Food Production. (1956) Insignificant Levels of Chemical Additives in Food. (1958)

Food Packaging Materials—Their Composition and Use. (1958)

Problems in Evaluating the Carcinogenic Hazard from Use of Food Additives. (1960)

Principles and Procedures for Evaluating the Safety of Food Additives. (1960)

The Use of Chemicals in Food Production, Processing, Storage, and Distribution. (1961)

We can take pride in the fact that the Chairman of the Food Protection Committee is a physician, William J. Darby, Director, Division of Nutrition, Vanderbilt University School of Medicine. Two of the ten members of the committee are from Illinois: Dr. Paul R. Cannon, University of Chicago, and Dr. George C. Decker, Agricultural Experiment Station Urbana.

*These and other reports from the committee are available through the National Academy of Sciences— National Research Council, Washington, D.C.

The Third Party Buffer Committee

H. Kenneth Scatliff, M.D., Evanston

THE TERM USED as a title is applied to those committees known variously as Insurance Company Grievance Committees, Insurance Board of Review, Prepayment and Organization Committees,¹ Review Committees,² Judiciary Committees and the like. The function of such a committee is to act as intermediary for the medical society and its members and the third parties paying for medical care. Most situations requiring a review relate to medical care, excessive usage of hospital care, excessive charge for care, and questionable services.^{3,4}

More and more does the third party occupy the arena of payment for medical care. An early arrangement consisted of gifts of money by fraternal orders to its members in time of need; such money was collected by dues or assessments. Later there developed the phenomena of insurance companies - health insurance agencies - guaranteeing payment of a fixed sum for this or that surgical procedure, passing later into the present era of the third party paying for complete medical care provided only, that the charge be "reasonable, usual and customary." Spurred forward, this movement has been aided by the ambition of insurance companies looking for more business, by inflationary costs resulting from uncontrolled spending, by powerful labor unions desirous of securing more fringe benefits for their members, and the very real threat of government intervention with the ultimate deterioration of medicine as we know it. Abetted it has been by the apathy and self-satisfaction of the profession, by vigorous workers within our ranks, and an entire lack of social perspective. It is sad too, because the plight of the Greek slave physician doing

the bidding of his powerful Roman overlord is a matter of recorded history.

Obviously when a third party — whose only interest is a financial one — comes between a doctor and the sick individual receiving his care, certain problems are created. This is not to decry the usefulness of a mechanism wherein groups will share in a common fund they have created to meet the expenses of an illness; we must emphasize, however, that the doctor now faces a more rigid economic fact of life.

Whereas the doctor once donated his service to the individual unable to pay and made it up elsewhere in his practice, he must now eome to terms with the third party who will pay for the medical service. This so-called third party is forced by the economics of our system to purchase as much as he can for his outlay and to reserve for himself a certain excess in the form of profit and reserve. This mechanism has appeal to the prudent and frugal individual aware of future uncertainties relating to his health. It leaves unprovided for, however, those individuals unable to gain the protection of the fund for reasons of poverty, their lack of employment, or type of employment.

Traditionally the physician has concerned himself with the welfare of the sick individual. If funds were not available for expensive drugs or hospital care in a given case, he made do with what was available. Today the climate of opinion indicates that this is not sufficient. The use of the insurance method or pooled funds is the only method available to us if we are to continue to solve our problems on the private enterprise level.

The committees called upon to consider

problems arising out of third-party contracts must keep three things in mind:

- 1. The public, our patients, must continue to receive the best care physicians of the United States can render.
- 2. Education in the matter of shared benefits is a continuing one for the companies involved, for the attending doctor, and for the committee.
- 3. For the future welfare of society the integrity of the profession must be maintained. Selfish interests of any individual or group must be recognized and not permitted to influence just consideration of any claim.

No case should be presented to these committees for review until the third party has made every effort to achieve a mutual understanding with the patient and with the doctor. The reviewing committee is composed of equally busy doctors who donate their services in an effort to solve some of society's problems. The presentation of any case for review should be in toto: all of the facts including the names of the doctor and the patient. Only by such disclosure can a complete investigation, equal to that of the company, be carried forward. Anonvmous discussions can be prejudicial.1

Excessive use of medicaments, physical agents for therapy or diagnosis, or hospital care can only be considered on an informal basis. Appropriate committees, associated with individual hospitals, have a greater opportunity to investigate such matters. This does not preclude contact between such committees and review committees representing a medical organization.4

In point of fact, the review committee with which the writer is most familiar does make itself aware of all circumstances of the hospitalization.1 This query goes hand in hand with exploration of all facts of the case under consideration. The committee has frequent occasion to remind itself that hindsight and personal knowledge give a different view than a mere set of figures and isolated statements.

A fairly recent development is a lessening of third-party contracts calling for a definite sum to the insured or to the doctor on proof of claim and a corresponding increase in policies assuring payment of all "reasonable, usual and customary charges."5 This broad concept, veering away from the "indemnity" principle and encouraging the "service" type of coverage seems to have gained acceptance by our medical leaders. We have interpreted this requirement to mean the consideration of

- 1. The customary charges in a given community for professional services of a like na-
- 2. The time and professional skill required and
- 3. The ability of the patient to pay.

In summary then, such a committee may consider its duty to be the recommendation for consideration by third parties such programs as will first assure the provision of good quality medical care at reasonable cost to the patient and secondly, to assure ourselves that the members of the profession are not involved in misrepresentation and fraud. The physician in turn, helps to prevent sabotage of the medical care program offered by the third-party payer.

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THE EYES OF OTHER people are the eyes that ruin us. If all but myself were blind, I should want neither fine clothes, fine houses, nor fine furniture.— Benjamin Franklin



Official Business

Special House of Delegates Action on Kerr-Mills

Interpretation of the Kerr-Mills Bill in Illinois has presented the officers of the Illinois State Medical Society with a dilemma. Should the Society support an unreasonable interpretation of a reasonable bill, or should the Society protest and try to secure a more liberal interpretation?

The Kerr-Mills Bill, as it is written at the national level, provides matching funds to the states for medical care for those over 65 who qualify according to standards established by the states. On the final day of the 1961 legislative session in Springfield, S.B. 197, the implementing law in Illinois, was passed. The law allows payment for a broad spectrum of services to persons over 65 who can qualify under reasonable standards of income and net worth. The Illinois Public Aid Commission is charged with the administration of the law and is given the power to specify the type of services actually provided at any stage of the program. A total of \$20 million, including the 50 per cent Federal matching funds, was made available for the current biennium.

As a result of the limited appropriation and the difficulty in predicting costs for this type of program, the Public Aid authorities adopted an extremely conservative view toward services. Payment was initially limited to hospital charges and 30 days post-hospital physician care, the minimum necessary to obtain U.S. Department

of Health, Education and Welfare approval for Federal matching. Rules and regulations for the program were drafted by the staff of the IPAC and presented for approval of the Commission without consultation with the Illinois State Medical Society or other vendors. Contrary to specific provisions in the law, the fees paid under the categorical programs were established as the fees to be paid under the new program without prior consultation with the vendors.

These developments were viewed by the Society as highly unsatisfactory to both the recipients and the vendors. The Council of the Illinois State Medical Society, under powers granted by the Constitution and By-laws, appointed a committee to meet with the Illinois Public Aid Commission to protest the inequities. After a hearing, the Illinois Public Aid Commission decided that sufficient funds were available to pay the in-hospital doctor bills in the downstate hospitals. In Cook County, recipients of care under Kerr-Mills would continue to pay their doctor bills themselves, or they would go unpaid. No concession was granted on fees.

It should be understood that the restriction placed on the payment of physicians' services to hospitalized patients in the voluntary hospitals in Cook County is not confined to the Kerr-Mills program. This ruling has always applied under the regular IPAC medical program. It has its origin in the interpretation placed upon the use of welfare patients in the

teaching programs. In view of the large number of welfare patients served in the voluntary hospitals in Cook County, recommendations from the Chicago Medical Society have recently been submitted to IPAC to alter this policy. A change in this policy involves additional expenditures beyond those required in the Kerr-Mills program.

This was the situation with which the Illinois State Medical Society was confronted. The special Ad Hoc Committee on Kerr-Mills recommended, and the Council agreed, that the House of Delegates ought to make the decision as to whether or not the Society should support the program under these conditions. Therefore, a special meeting of the House of Delegates was called on Saturday and Sunday, October 28-29, 1961. Every member of the House had three opportunities to be heard. At the first session opportunity was given to introduce resolutions and to interrogate the Ad Hoc Committee. At the Reference Committee meeting all had an opportunity to discuss the resolutions. At the final session on Sunday, everyone had an opportunity to discuss each section of the Reference Committee's recommendations. These recommendations were passed by an overwhelming majority.

The recommendations, in principle, advised cooperation with the Illinois Public Aid Commission in the Kerr-Mills program for a trial period of six months, after which the program would be reviewed with members of the Commission to determine the nature of further support. The six-month trial period was selected to allow time for the accumulation of adequate cost data. Regardless of considerations which involve attitudes and general relations to the IPAC program, the underlying problem is money. The present appropriation is probably not sufficient to provide all of the services authorized under the law. The amount of service which can be provided within the \$20 million appropriation remains a debatable question. Additional appropriations must await the 1963 session of the General Assembly.

The House of Delegates has met and rendered its considered opinion in support of this program for a six-month trial period. The objections which the Society finds in the program have been forcefully presented to the Illinois Public Aid Commission. The special Ad Hoc Committee is continuing its work and expects to fulfill its obligations to meet with the members of the Commission to review the program at the expiration of the trial period. Resolutions coming before the 1962 House of Delegates of the Illinois State Medical Society should take into consideration practical solutions to the problems which the Society faces in this program.

Walter C. Bornemeier, M.D. Presiding Officer, House of Delegates

ISMS Relative Value Study

Drs. Ekeblad and Parl, the statistical consultants to the Society's Relative Value Study, have submitted to the Committee on Relative Value their report and the relative value index numbers for 600 medical and surgical procedures included in the survey questionnaire. These procedures will serve as the statistical base from which interpolations will be made for procedures not included in the questionnaire. Interpolations will be made in cooperation with representatives from specialty societies and the Academy of General Practice.

The 1961 House of Delegates resolved that a copy of the results be sent to each delegate and three copies to each specialty society for study of the practical application. Copies will be marked "Preliminary Proposal, Confidential." The House must vote favorably on the results before they are prepared for general distribution.

Committee on Relative Value

At the request of the Relative Value Committee and with the approval of the Council of the Illinois State Medical Society, we have designed a relative value study for about six hundred procedures, the nomenclature of which had already been applied in similar relative value studies conducted by the state medical societies in California and Michigan.

This study was designed as a stratified probability sample, divided into 33 groups by 3

geographic areas and 11 specialty groups. The three geographic areas were as follows:

Population				
	(In Mil-	Per	No. of	PER
AREA	lions)	CENT	PHYS.	CENT*
Chicago with				
contiguous				
suburbs	4.3	42	7,859	60
Other places				
with population				
over 25,000	1.5	14	2,797	21
Other places				
with population				
under 25,000	4.4	43	2,361	18
TOTAL	10.1	100	13,017	100

^{*}Percentages do not add to 100 due to rounding.

The 11 specialty groups represented general practice, surgery, internal medicine, obstetrics and gynecology, psychiatry and neurology, otology and ophthalmology, pediatrics, roent-genology and radiology, pathology, anesthesiology, and a general group combining the remaining smaller specialty groups.

A systematic sample of one of each four physicians was drawn from each of the eleven specialty groups in the three geographic areas.

The questionnaire was mailed on September 1 to all physicians in Illinois. Follow-up letters were mailed to all physicians requesting them to return their completed questionnaires. The deadline for all returns was October 10.

About 4,400 physicians responded. Usable questionnaires returned from physicians in private practice totaled 3,677. This represents 37 per cent of all physicians in private practice in the State of Illinois. Since the return from the sampled physicians was not quite as high as was hoped for, it was decided to include in the study all the returned questionnaires. This way a more adequate basis was obtained for a detailed analysis of the specialty groups by geographic regions, particularly after proper weights were assigned to the various groups in accordance with their total number.

For the purpose of analysis all of the information on the questionnaires was put on IBM

cards. A separate card was used for each procedure; as a result a total of 195,000 cards were key-punched.

These cards were then machine-processed to provide the following information:

- 1. The summary distribution of the fees charged for each procedure. Consideration was given to the frequency with which each physician performed the procedure.
- 2. Three statistical measures were then calculated for each procedure.
 - a. The median, or the typical middle fee;
 - b. The *first quartile*, or the middle fee of of the lower half of the distribution;
 - c. The *third quartile*, or the middle fee of the upper half of the distribution.
- 3. The relative value index numbers were then calculated by dividing the typical fee for a given procedure (as measured by the median and the first and third quartiles) by the corresponding typical fee for the *base* procedure (the routine office visit).

Thus three relative value index numbers were calculated for each procedure. These became the basis of determining the relative value index.

In most of the cases the ratio of the medians was in between the ratios derived from the quartiles, and the ratio of the medians was taken as the relative value index number. In other cases, when the ratio of the medians was one of the extreme ratios, the original data were consulted for evidence of erratic gaps in the reported fees. The relative value index numbers for the 600 procedures surveyed were then a modification from the ratio of medians.

It should be emphasized that the relative value index numbers for these procedures are based upon reports of actual fees charged. The numbers have not been modified to develop a Relative Value Index which might be considered acceptable or desirable from the viewpoint of any interested individual or group of individuals. The study presents the facts in an objective way representing the relative values of typical fees charged by the physicians in Illinois.

Frederick Ekeblad, Ph.D., Chairman, Boris Parl, Ph.D., Ass't. Professor Department of Business Statistics, Northwestern University

MEDICAL—LEGAL



Illinois Validates Consent of Certain Minors to Surgical Procedures

Walter L. Oblinger, General Counsel

Not infrequently, emergency situations have arisen requiring the performance of surgery or medical procedures upon minor persons. S.B. #821 passed by the Illinois General Assembly at the request of the Illinois State Medical Society and signed into law by the Governor Aug. 17, 1961, has validated consents executed by minors who have married, pregnant women who are minors, and parents who are minors, to medical or surgical procedures. The Act is as follows:

"Section 1. The consent to the performance of a medical or surgical procedure by a physician licensed to practice medicine and surgery executed by a married person who is a minor, or by a pregnant woman who is a minor, shall not be voidable because of such minority, and, for such purpose, a married person who is a minor or a pregnant woman who is a minor shall be deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

"Section 2. Any parent, including a parent who is a minor, may consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery. The consent of a parent who is a minor shall not be voidable because of such minority, but, for such purpose, a parent who is a minor shall be deemed to have the same legal

capacity to act and shall have the same powers and obligations as has a person of legal age."

Prior to the enactment of this statute a consent of a minor person to a medical or surgical procedure was voidable at the option of the minor at any time within a reasonable time after reaching majority. This state of the law presented a very real problem to physicians and hospitals who wanted to help those in urgent need of medical assistance, but who, on the other hand, did not want to be exposed to a suit for assault and battery at some future date. In some cases it has been necessary to seek a court order to overcome this problem. In other cases there was not sufficient time to do this. In these cases the hospital and the physician had to take a calculated risk and go ahead with the operation or procedure with the hope that they would not be sued. It should be noted, however, that S.B. #821 will not affect tortious liability other than assault and battery, such as malpractice or any breach of contract giving rise to actions sounded in con-

S.B. #821, by placing these minor persons in the same status as adults, should serve to remove all hesitancy on the part of physicians and hospitals to proceed upon a consent obtained from such a minor; and by eliminating all delay in emergency situations, serve to relieve those in pain and suffering and in need of immediate life-saving operations.

Interprofessional Code for Physicians and Lawyers of Illinois

THE FOLLOWING INTERPROFESSIONAL CODE for Physicians and Lawyers of Illinois was drafted by a Special Committee on Medical-Legal Cooperation of the Illinois State Bar Association and the Liaison Committee of the Illinois State Medical Society to serve as a guide to physicians and lawyers. It has been approved by the governing boards of both the Illinois State Bar Association and the Illinois State Medical Society.

PREAMBLE

The purposes of this Code are to establish standards of practice and of ethical conduct for physicians and lawyers in those areas in civil cases where there is and will continue to be an interrelationship of medicine and law, and thereby to improve the practical working relationships of the two professions, to protect the legitimate interests and rights of the patient-client, of the physician, the lawyer, and of society, and thereby to help advance the more effective administration of justice.

The provisions of the Code constitute recognition that the members of each profession have an obligation not only to the individual who obtains their advice and assistance but also to the community and society as a whole, and to all other members of their own professions. The objectives of the Code can be achieved only if the members of both professions acquaint themselves with these standards of practice and follow them, subject to rules of law and principles of medical and legal ethics.

ARTICLE I

ATTENDING PHYSICIAN'S
MEDICAL REPORTS AND CONFERENCES

Purpose of Physician's Report

1. Information relative to an attending physi-

cian's treatment of a patient whose physical or mental condition is an issue in litigation is of prime importance to the parties involved in litigation. To properly prepare his client's case for trial and to be in a position to properly represent his client in settlement negotiations, the patient's lawyer has the duty of acquiring pertinent information from the attending physician. During the course of litigation, it becomes necessary for the lawyer to correspond with and confer with his client's physician and to obtain written reports from the physician.

Keep Complete Records

2. The attending physician should prepare, keep and preserve full and complete records of his examination, diagnostic findings (laboratory), and treatment of the patient.

Request for Report

- 3. When a medical report is desired by the lawyer, he should make a written request for it from the attending physician, and this request should be accompanied by a written authorization from the client for the release of the information sought from the client's physician. The request should ask the physician to give the following specific information:
 - (a) History of the occurrence leading to the injury or condition, as given by the patient to the physician.
 - (b) Pertinent subjective complaints elicited from the patient.
 - (c) Pertinent objective findings made by the physician throughout the course of treatment.
 - (d) The physician's diagnosis.
 - (e) Interpretation of x-rays, electroencephalograms, electromyograms, and any and all other pertinent data used in the treatment and diagnosis (source of interpretation should be stated).

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- (f) Treatment rendered by the physician to the patient.
- (g) The physician's opinion as to whether there is permanent residual from the injury or condition and the extent thereof.
- (h) The prognosis.
- (i) The physician's opinion as to the necessity of further medical or surgical treatment.

The request for a report should be accompanied by a statement that the lawyer will endeavor to provide for the payment of the physician's fees out of any settlement or satisfaction of judgment.

The Physician's Report

4. The physician has the obligation to cooperate with his patient's lawyer and should as soon as practicable after receiving the request for it supply the patient's lawyer with a written report. This report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request for a report. In preparing the report, the physician should examine his own records and, where practicable, the records of any hospital he deems necessary pertaining to the treatment of the patient.

The attending physician should not give written or oral reports concerning his patient to attorneys, adjusters, or investigators representing parties whose interests are adverse to those of the patient without express written authorization from the patient.

Report Should Be Complete

5. The report to the lawyer should be objective, impartial and complete. The attending physician should not give, and should not be asked to give, a report that does not comply with these standards.

Conference Between Physician and Lawyer

6. Prior to the submission of a medical report by the attending physician to the patient's lawyer, conferences may be required between the patient's physician and lawyer. Conferences at the request of either the physician or the lawyer should be arranged at the mutual convenience of each. At the conference there should be candid discussion of the medical aspects of the litigation to promote complete understanding between the patient's physician and lawyer.

ARTICLE II

Examining Physician's Medical Reports

The "examining physician" as the term is used in the Code, differs from the "attending physician" and the "expert" in that he does not prescribe treatment and is not necessarily expected to testify at the trial. His examination is made at the request of the lawyer for one or both of the parties or at the request of the court. Should he later testify at the trial he testifies as an expert.

Request for Examination and Report

1. Where the examination is made at the behest of either party, a written request for examination should be sent to the physician by the lawyer asking for the examination stating the nature of the examination desired.

The request should be specific and request the physician to give the following information:

- (a) Pertinent subjective complaints elicited from the patient.
- (b) Pertinent objective findings made by the physician.
- (c) The physician's diagnosis as of the time of the examination.
- (d) Interpretation of x-rays, electroencephalograms, electromyograms and any and all other pertinent data used in the diagnosis (source of interpretation should be stated).
- (e) The physician's opinion as to whether there is a permanent residual from the injury, and the extent thereof.
- (f) The prognosis.
- (g) The physician's opinion as to the necessity of further medical or surgical treatment.

Report of Examination

2. The examining physician should send the report of the examination to the lawyer requesting the examination as soon as practicable

after the examination. The report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request.

Report Is Confidential

3. The examining physician shall not give medical information to the opposing lawyer without the authorization of the lawyer who requested the examination, unless the examination is pursuant to order of court.

Keep Complete Records

4. The examining physician should prepare, keep and preserve full and complete records of his examination and diagnostic findings (laboratory).

Report Should Be Complete

5. The report to the lawyer should be objective, impartial, and complete. The examining physician should not give, and should not be asked to give, a report that does not comply with these standards.

Examination at the Request of the Court

6. Provisions for examination at the request of the court, and the procedure to be followed, are covered by rule of court or by statute.

Copy of Report to Employee in Workmen's Compensation Cases

7. In Workmen's Compensation cases, the examining physician selected by the employer is required to deliver a copy of his report to the injured employee or his lawyer, unless the employee has a physician of his own selection present during the examination.

ARTICLE III

MEDICAL FEES

Attending Physician

(1) The attending physician of a patient

whose physical or mental condition is the subject matter in litigation may, in the manner provided by the Statutes of the State of Illinois, perfect his lien for medical fees for his services rendered to the patient. (See Appendix for suggested form of lien notice.)

(2) The physician should also notify the lawyer for the patient of his lien by sending him a

copy of the Notice of Lien.

- (3) The lawyer for the patient should explain to his client the nature of the lien and necessity for satisfying it out of any recovery. The lawyer should take all reasonable steps to assure payment for the physician's services out of any recovery made for the client. If the lawyer finds that he cannot accomplish this, he should notify the physician immediately so that he may take steps to enforce his lien. (See Appendix for suggested form of authorization to be used by lawyer.)
- (4) In the event that the attending physician expends time in preparing a report, in appearing at a deposition or in court, or in any other manner for his patient, the physician shall be entitled to a reasonable fee from his patient. The lawyer shall take all reasonable steps to see that his client pays the said fee.
- (5) The attending physician shall not charge his patient a higher fee because the patient may recover the amount of these charges as the result of a claim or litigation.
- (6) The lawyer should not pay the attending physician's fee, except with the client's funds.
- (7) The physician's fee shall not be contingent upon the outcome of the litigation.

Examining Physician

- (1) A physician who makes an examination at the request of a lawyer shall charge the reasonable value of his services so rendered on the same basis as if his services were not rendered to a patient in connection with litigation. The physician's charge for reports, conferences with the lawyer, and appearances at depositions and in court shall also be based upon the reasonable value of those services.
- (2) The said charges shall be the obligation of the client and not of his lawyer. The lawyer shall make every reasonable effort to see to it that his client pays the fee of the examining

physician for all services rendered by the physician to or in behalf of said patient.

(3) The examining physician's fee shall not be contingent upon the outcome of the litigation.

Experts

- (1) The physician whose services may be rendered as an expert in connection with any phase of litigation, shall not charge more than the reasonable value of his services. The fee shall be the obligation of the patient-client and not of his lawyer.
- (2) The lawyer shall make every reasonable effort to see that his client pays the fee of the expert.
- (3) The expert's fee shall not be contingent upon the outcome of litigation.

ARTICLE IV

THE PHYSICIAN AT THE TRIAL OR HEARING ON DEPOSITION

Conferences Prior to Trial

- (1) The lawyer and the physician should arrange to confer with each other before the physician testifies at any hearing, and if possible, before the trial commences. At the conference the common problems involved in the case should be discussed. The lawyer has the responsibility of acquainting the physician with any particular legal problems which might involve the physician, and with the assistance of the physician should determine the areas in which the physician will be called to testify. The lawyer should familiarize the physician with the contents of any proposed hypothetical questions.
- (2) The physician should make every effort to cooperate with the lawyer in regard to this conference. Each should be mindful of the demands on the other's time in making appointments for conferences, in the time spent on conferences, and in notifying the other promptly if, for any reason, either is unable to attend the appointed conference. While the physician should recognize that he is not an advocate and the lawyer is, he should at the conference familiarize the lawyer with the medical problems involved, the areas in which he (the physician)

feels qualified to testify, and the facts and opinions about which he is prepared to testify.

Court Arrangements

- (1) The lawyer should make every effort to be economical in his use of the physician's time. He should give the physician reasonable advance notice of when and how long he shall be needed in court, advise the physician promptly of any changes in the time of his needed appearance, and should call the physician as a witness upon his arrival at court, with as little delay as possible.
- (2) The physician has an obligation to be in court at the time requested. He should recognize that only a true emergency will excuse his non-attendance. In the event that such an emergency does arise, he should, as soon as possible, notify the lawyer who requested his appearance in court of his inability to be in court at the appointed time and also advise as to the earliest time he will be available to testify.

Subpoenas

- (1) The lawyer should determine whether or not the physician should be served with a subpoena. If the physician is to be served with a subpoena, the lawyer should advise the physician of the reason for serving him; for example, that service of a subpoena is necessary to lay the foundation for a continuance if the physician is unable to attend the trial due to an emergency or other cause. If service of a subpoena is to be had, the lawyer should advise the physician in advance, and if possible, arrange for the service of the subpoena at a time and place satisfactory to the physician.
- (2) The physician should recognize that a lawyer may deem is necessary to subpoena the physician, and that the physician is obliged to answer the subpoena as any other citizen. He should cooperate with the lawyer with regard to the time and place of service.

Conduct As a Witness

(1) It is improper for a lawyer to attempt to color or otherwise influence the professional opinion of a physician.

(continued on following page)

(2) The physician's testimony should be unbiased and given in terms understandable to the jury. He should be prepared to testify in detail as to his qualifications, the medical facts in the case, and to give his frank and honest medical opinion in regard thereto. Technical or medical terms, if used, should be carefully and fully explained. The physician should remember that he is not an advocate trying a lawsuit, nor should he feel that he is taking sides on any particular medical issue or fact.

Interrogation of the Witness

(1) The physician and the lawyer, as professional men, should treat each other with the utmost respect and courtesy in the courtroom.

- (2) No lawyer is justified in abusing, badgering, or browbeating a physician appearing as a witness. Established rules of evidence give ample opportunity for testing the competency or credibility of a medical witness or the weight to be accorded his testimony.
- (3) The physician should understand that he may be cross-examined with respect to his qualifications, his fees, any financial interest he may have in the case, the accuracy of his records, or his memory, the soundness of his diagnosis, prognosis, and other facts properly bearing upon the credibility of, and the weight to be accorded to his testimony.

A suggested form of physician's lien notice is as follows:

NOTICE OF LIEN

In favor of John M. Jones, M.D. 1424 Chestnut Street Springfield, Illinois

TO:day of	, 19
I am advised that	
whose address is	
has a claim, right, or caus	
you for injuries received,	
accident on or about	
You are notified that I cla	im a lien upon such

claim, right, or cause of action for reasonable charges for medical services rendered said ______ on account of said injuries, the total amount of such lien not to exceed one-third (%) of any sums due or paid to such injured person by compromise, settlement, or satisfaction after the satisfaction of any attorney's lien, if any.

This lien is claimed pursuant to an Act providing for a lien for physicians rendering treatment to injured persons approved July 23, 1959 (Chap. 82, Sec. 101.1, Ill. Rev. Stats., 1959).

Money paid in settlement of this claim or in settlement or payment of any judgment or decree on this claim is subject to this lien, and before making settlement, you should consult with me and see that this lien is satisfied.

Signature

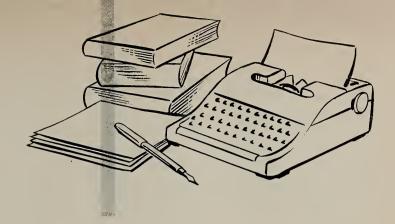
(This notice to be served on both the injured person and the parties against whom such claim or right of action exists, by certified mail or in person.)

Suggested form of authorization to be used by lawyer:

(Place) (Date) ____, hereby "I, _____ authorize and direct _ my attorney, or attorneys, to pay from the proceeds of any recovery in my case to Dr. _____ the reasonable amount for professional services in the treatment of injuries sustained by me and/or my wife and/or my child or children, as the case may be, in an accident which occurred on _ 19____, said payment to include professional services heretofore rendered and those rendered to the time of the settlement or other disposition of my case for the treatment of said injuries, and fees for testifying in court."

"I further authorize said Doctor to furnish said Attorney with any reports he may request in reference to my injury. I understand that this in no way relieves me of my personal responsibility to pay all such medical charges."

Witness	Witness	Signed
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Editorials

Our Stake in Kerr-Mills System

Secretary Abraham Ribicoff hammered away at his pet project in his year-end statement—
"Finally, in this brief review, I want to call attention to the major and most pressing unfinished business in the field of health today. This is the need for a national system of prepaid health insurance for those with the highest medical bills and the least financial means—the older people of America.

"It is a national disgrace to leave millions of older people to fend for themselves or force them to plead poverty or its euphemistic twin, 'medical indigence,' in their hour of need when other means are at hand.

"The time-tested social security system offers such a means, and the next session of Congress will be asked to allow the American people to avail themselves of it without further delay."

The selling point for medical care for the aged through social security appears to be one of sympathy. It is aimed at face-saving for the "millions" who must "plead poverty." Many socialists have reached the top with this appealing philosophy, and many of our laws are made to satisfy this small segment of our population.

Our first objection to the King-Anderson bill is it is an opening wedge in the door to socialized medicine. Once begun, this socialistic reform progresses more easily. We wonder how many of these "millions" were "medically indigent" before they reached age 65? Thus, by like reasoning children will be the next group to be included, then everyone over 50, and finally all of us. The children will be the easiest to sell, especially when our welfare groups resort to the "old pitch" of doing something to improve our unhealthy, sickened, weakly youth. This comes up every time we have a recruitment for the armed forces, but the government neglects to tell us how many of the

rejectees have specific disabilities such as myopia, dental caries, rheumatic heart disease, obesity, and psychoneurotic disorders.

We also object to a national system of "prepaid medical care via social security" because it is a burden to the young man. He may never realize the benefits — and if he should, the price is high because of the usual inefficiency and waste of bureaucracy.

There is no doubt that a single plan of operation has merit. All welfare under one system would eliminate duplication and theoretically is the most logical method. But we have all seen what happens when one agency becomes too big and powerful.

The suggestion that the federal funds be paid into voluntary agencies such as Blue Cross also is worthy of consideration. The organizations run the risk, however, of being swallowed up by the "hand that feeds them" after the first financial crisis, scandal, or major complaint.

Meanwhile we have a going plan in Illinois that we should support. Let us fight to preserve it if it meets the demands of the citizens. If not, we should be the first to admit it.

Paying the Price

Britain's supply of physicians is gradually rising under its national health plan, but not as rapidly as hoped nor in the manner intended. British-trained physicians are leaving England at the rate of 600 a year, and less well trained foreign doctors are flocking in at the rate of about 1,000 a year.

Figures from the Ministry of Health show that of 9,541 junior doctors employed in British hospitals only 5,913 are British trained. Most of the others are from India and Pakistan.

Lures for the Britishers are Canada or the United States, where they can practice without government control; or Australia or New Zealand, which offer more opportunity in private practice than does England, in spite of social security health plans.

The beginning pay for a full-time doctor in British hospitals is only \$1,360 a year — a sum sufficient to attract young doctors from Asia, especially when coupled with the security of government work. For British physicians, however, there is a great incentive to look for something better.

Also, Britain's medical schools are not turning out as many new doctors as we are in relation to the country's population. And even our 7,000 yearly medical school graduates fall 2,000 short of what we are told we need.

When a government tries to provide health care to everyone, free or at discount rates, and at the same time support itself and remain within its income, this sort of thing might be expected. You pays your money and you makes your choice.

Facing Death

An effective doctor-patient relationship is one of mutual trust. Should this be maintained to the bitter end, or should the physician withhold information of impending death from the patient? Avery D. Weisman, director of the Psychiatric Consultation Service of Massachusetts General Hospital, believes that many patients would be willing, even anxious, to discuss impending death if their doctors could bring themselves to face the problem. He believes that dying is a state of loneliness brought about by the isolation which the living force upon the patient. Even euthanasia, according to Dr. Weisman, is designed to ease the anguish of the survivors, not the patient. Most physicians withhold the truth perhaps because they believe that hope can be maintained in this way.

But truth, he says, is not necessarily synonymous with dispair. Dr. Weisman conducted research on "a small group of pre-operative patients who correctly predicted their own deaths." They were prepared to die and baffled the attending physicians by the absence of anxiety and depression. They were convinced that death was desirable because organic illness would be relieved, and it would resolve their conflict.

Control of Research

Organized medicine has been of little help to the pharmaceutical manufacturers in their battle with Senator Kefauver. No one has because of the nature of the hearings.

We have received many news releases from both sides, and it is obvious that the so-called Kefauver Compulsory Licensing Bill (S-1552) would weaken pharmaceutical industry research. It would reduce patent protection of drug inventions from 17 to 3 years and require the government to determine relative efficiency of drugs.

The intelligent use of new drugs developed by the industry has assisted in saving countless lives during the past years. It is true that some sick persons cannot afford these products, but in the long run the majority of our new drugs have lowered the over-all cost of medical care by reducing the period of disability.

Every group has its rotten apples, but why should an industry that has done so much for mankind be dragged in the mud and penalized so severely. Furthermore, pharmaceutical companies have the support of many of the ablest people in the medical profession. Men in government do strange things, and some day we will know the real reason behind this fiasco.

Dr. Ernest Volwiler, retired board chairman of Abbott Laboratories, believes that research progress would be set back by the proposed Kefauver bill. "Few firms would engage in extensive research. New prescription drugs would come at a slow rate. . . . Creative, research-oriented companies would become run-of-the-mill manufacturers, turning to such areas as cosmetics, toiletries, and specialized food products."

There is a good possibility that this investigation would never have come to pass had the medical profession maintained the major role in the evaluation of new drugs.

Locusts and Wild Honey*

Few of its fellows would be so chauvinistic or themselves so uncritical as to claim anything approaching infallibility for the American Medical Association. Criticism of the Association by various newspaper editors, independent columnists and free-lance writers, however, is often so prejudiced that those who are familiar with its organization, purpose, and scope are at a loss how to combat what is either bad reporting or bigotry and deliberately designed partisan propaganda.

The Association, no more and perhaps no less perfect than any similar large representative body, has been scorned and excoriated for sins it never committed. It has been described as having power and controls it has never had and, God willing, never will have. It has been misrepresented, misinterpreted, and mercilessly maligned.

Robert C. Ruark's syndicated column in the Boston Traveler for January 4, 1961, is a case in point. Ruark wrote: "... the physician is blackmailed into membership in one of the toughest unions in the world, the AMA, which can wreck him if he bucks the union and which will cover up for him if he errs and is found out..." More recently, as reported in the Traveler on March 20, Secretary of Health, Education, and Welfare Ribicoff accused the Association of exercising "very strong sanctions against individual doctors who speak up their mind."

Other critics have claimed that the Association opposed the original adoption of social security, workmen's compensation, mass vaccination, medical care for the aged, and the expansion of medical education. Without knowledge of the facts, lay critics have condemned it as a self-interested group with no concern whatsoever for the well-being of the patients whom physicians are pledged to serve.

How does one answer a diatribe when its author seems to have disregarded completely facts readily available? Rebuttals have little effect. The antiorganized-medicine champion, self-righteous in his indignation, is beyond reproach and immunized against fact.

As any delegate, officer or informed member of the Association knows, objective, factual criticism is desired, welcomed, and accepted without resentment, but the informed member does resent the malicious distortions made by the opponents of organized medicine. These, nevertheless, he must accept from whence they come and answer as best he can without resorting to the same tactics.

Criticism that cuts more deeply, however, is that which, basically unfactual, comes from

members of the Association themselves or from eligible physicians who have not joined the organization that is still supposed to represent them nationally.

Not joining, or resigning as a member, accomplishes nothing. The House of Delegates sets the policy. The delegates are elected by the members of their respective state medical societies, whom they represent on the floor of the House. The majority decision of the House prevails. The majority is not always overwhelming, and if the minority is strong and willing to work for the adoption of its point of view, it can, and has, become the majority.

A physician who strongly opposes an Association policy may, on district, county, and state level, work to change it. If he can convince the majority of physicians in his society that his stand is just and correct, the society's delegates will espouse his cause at meetings of the House. He can appear in person and discuss any resolution up for consideration by a reference committee. The physician who resigns from membership or refuses to join "as a matter of principle" weakens his own cause.

The physician, member or nonmember, who criticizes the Association without a knowledge of its structure and purpose, without participation in the affairs of his own state medical society and without a clear understanding of the facts on the issue he criticizes, plays into the hands of those critics whose objective is disorganizing medicine.

Many persons believe that marked changes, some of them drastic, should be made in the distribution of medical care; that not only publichealth technics but personal medical attention should become a Government responsibility; that the traditional private practice of medicine on a fee-for-service basis has become completely outmoded. Tax-supported medical care has come to be looked on as a basic right by those who still would not think of applying the same principles to the provision of food, clothing, and shelter on such a scale and without a means test.

There are, on the other hand, just reasons for criticizing the private practice of medicine as conducted by some individuals. As in every other profession in which the sale of its members' services provides them with their living, there are those in medicine who are incompetent and who exploit the physician-patient relation to their own advantage. Regardless of the method of his payment the good physician is concerned primarily with the well-being of his patient. He can scarcely serve beyond the call of duty because his duty has no prescribed limits. Before he makes his decision to enter the profession he should spend, in effect, his forty days in the wilderness. He should know that he is possessed of humility, a willingness to make personal sacrifice, and a sense of dedication. Then he may be given to eat of the hidden manna.

*Reprinted by permission from The New England Medical Journal, 264:828 (April) 1961.

The Wrong Patient

We discovered another reason why the British surgeons are called mister. The Medical Defense Union handles their malpractice problems, and according to the *British Medical Journal* has twice warned physicians about operating on the wrong patient or the wrong part of him. The Medical Defense Union dealt with 28 cases of this kind of mistake during the past two years. In fact, they are so difficult to defend that the union prepared a memorandom (with the help of the Royal College of Nursing) on ways to avoid such errors. The main recommendation was to label or mark the patient before he reaches the operating room.

This was "intended to ensure that the right patient reaches the operating table," but "another set of recommendations were designed to ensure that the surgeon operates on the right part. The basic safeguard suggested is that the side on which the operation is to be performed should be indelibly marked on the patient's forehead before he reaches the theatre."

Enough is enough.

These recommendations do not speak well of British surgery or operating room procedures. It has all the earmarks of an assembly line workshop where the surgeon sees the patient for the first time and performs the operation he is told to do. He must read the marker to tell what fingernail to remove and whether he is operating on the right patient.

Featherbedding

Medical featherbedding is one of the most common complaints brought bfore the Grievance Committee, according to Dr. E. L. Cole, Jr., of Picomeso, Florida. The term usually denotes the unnecessary employment and payment of an individual. In the practice of medicine, featherbedding is charging more than one fee for the same illness. This is justifiable in many instances, but all too often the committee is unable to determine the actual care given by both physicians.

The typical case, according to Dr. Cole, is the patient admitted to the hospital for surgery either by referral or by the surgeon himself. The patient is surprised or pleased when the referring physician drops in to see how he is getting along. But on being discharged from the hospital, the patient is upset when he gets a separate bill from the nonoperating physician. The fee may range from \$5 to \$10 per day for his entire hospital stay. This featherbedding may at times cost the patient as much as \$150.

The question is asked: How many doctors does a patient need? This depends upon the nature of the illness or surgery required and the condition of the patient. The ability and medical knowledge of the attending surgeon must also be taken into consideration. But there are many times when there is no need for the services of a second or third physician, especially in the care of a small infant, the chronically ill child or adult, and the elderly debilitated patient.

It is good public relations to drop in and see patients that you have referred. They should be charged if you enter into the responsibility of their pre- and postoperative care. But the patient should be informed ahead of time so that he knows what to expect.

If the surgeon is nothing more than the technician, according to Dr. Cole, he should get a technician's fee, and you get the fee for doing the thinking.

When I'm getting ready to reason with a man, I spend one-third of my time thinking about myself and what I am going to say—and two-thirds thinking about what he is going to say.—Abraham Lincoln



CEREBRAL VASCULAR DISEASE

The death rate from cerebral vascular disease rises rapidly with age. It is 33 per cent higher in males than females in the ages 55 to 64 but only 11 per cent after age 75. Overweight and hypertension have an adverse effect on mortality. In the obese, for example, the excess mortality is 115 per cent. Those with blood pressure readings of 148-177 mm. systolic and 93-102 mm. diastolic have a mortality rate almost six times that for standard risks. Heredity also enters the picture. According to the Statistical Bulletin, the mortality from cerebral vascular lesions was 69 per cent higher in those whose immediate family had two or more cases of cardiovascular renal disease before age 60.

Pap Smear vs. Acridine Orange

The Papanicolaou stain used in the diagnosis of lung cancer has a strong competitor in the form of Acridine Orange. According to Dr. Davis S. Rome, director, Cytology Laboratory, Albany Medical College, the latter can be done by an untrained individual in half the average time spent per Papanicolaou slide. Sputum slides stained by Acridine Orange and examined with ultraviolet light were given to technicians who had no cytologic training. They were provided with recent papers on fluorescent microscopy and told about the characteristics of malignant cells. Their interpretations were compared with duplicate slides, stained by the Papanicolau method and classified by trained cytotechnicians. Sputum was obtained from 500 patients, among whom were 54 cases of primary bronchogenic carcinoma and 24 with other types of cancer. False interpretations by both methods were obtained in 12 cases. Cytologic results were approximately the same by the two methods: 64.2 per cent of cases of primary lung cancer were suspicious or positive by Papanicolau stain and 58.8 per cent by Acridine Orange stain. By using a combination of the two methods an accuracy of 70.4 per cent was obtained.

PHARMACEUTICALS

Fluoride has been added to Upjohn's new pediatric vitamin drops (Adeflor). It is to be used only in areas where the fluoride content of drinking water is known to be less than 0.7 parts per million. A dropperful of Adeflor (0.6 cc.) provides 0.5 milligrams of fluoride.

Imferon, Lakeside Laboratories' intramuscular iron-dextran complex, is returning to the market. The product has not been changed, but new packaging and labeling have been prepared. According to Lakeside, Imferon is a well-tolerated isotonic solution of iron-dextran complex that is indicated in those patients with iron deficiency anemia in whom oral administration of iron is unsatisfactory or impossible.

Low Caloric Pork

A project carried out by various livestock and meat organizations discovered that bacon and pork have fewer calories than we have been led to believe. The new determinations were made on the cooked cuts of meat, which is the way meat is eaten. Previous estimates were made from uncooked cuts of meat.

As a result, Dr. William C. Sherman, director of nutrition research of the National Live Stock and Meat Board, now objects to listing bacon and pork products in the high caloric category. "Such listing," Dr. Sherman said, "is based on outdated beliefs rather than modern research findings." Board-sponsored research at Oklahoma State University in 1956-57 showed cooked pork to have 36 per cent fewer calories, 57 per cent less fat, and 22 per cent more protein than previous food composition tables had indicated. The new figures are based on careful measurements of a large number of different cuts of pork.

Similar figures were obtained on beef and lamb. There are more than 40 different cuts of pork, beef, and lamb which contain less than 350 calories per 3½ ounce cooked serving, which makes them ideal in a safe, effective weight-reducing diet. There are 10 cuts of pork alone which contain less than 350 calories per serving.

AIR PURIFIER CLAIMS FALSE

Household air purifiers commonly sold in retail stores are not effective in preventing or treating respiratory ailments, sinus trouble, or allergy conditions, the Food and Drug Administration said today in announcing the results of a court action involving the nationally promoted Puritron line of such devices.

The case involved two types of Puritron devices seized in a Washington, D.C., retail store in October, 1959, on charges that they were misbranded by false and misleading therapeutic claims in their labeling. Both contained small air filters with electric fans to circulate the air and ultraviolet lamps capable of producing a small amount of ozone gas.

Experiments conducted by FDA have shown that such devices have no significant effect in ridding the air of contaminants and dust and will afford no relief to suffers of asthma, hay fever, allergies, and sinus conditions. The Puritron device is similar to many other so-called air puriflers that the FDA has proceeded against.

AMERICANS BETTER THE FRENCH

Someone said that "Only the French can improve on the douche." Maybe so, but Minute Hygiene was introduced last year as "an Amer-

ican invention that revolutionizes the modern bathroom." Their news release left nothing to the imagination—"With one bold inventive sweep, an ingeniously designed American appliance, rendering the awkward douche and the embarrassing bidet obsolete overnight, draws the American woman up to and ahead of her European sister in an area in which this land of scientific advance and limitless consumer technology has lagged sadly behind the Old World—woman's 'most intimate' personal hygiene."

The appliance is somewhat smaller than a tissue dispenser and is attached under the wash basin, on the bathroom wall, or on the toilet flushometer. Accessories include a vaginal nozzle, two rectal nozzles for adults and children's use, a dispenser for medication, (antiseptic, liquid soap, or shampoo) and a spray nozzle. Water tapped directly from the bathroom supply is controlled by hot and cold water dials on the face of the appliance. The release also came with pictures, one with a pretty girl in a nightie.

ROBINS EXPANDING RESEARCH

A. H. Robins Company, Inc., an 83 year old ethical pharmaceutical manufacturing firm, is building a \$1½ million research laboratory in Richmond, Va. The expansion is justified because research is the backbone of the pharmaceutical industry. Robins has doubled its staff and research areas. It now spends \$2 million a year in research.

VA LARGEST TRAINING GROUND

Prior to World War II most Veterans Administration hospitals were in the country or on the edge of town. They had difficulty obtaining a staff and played a minor role in medical education and reasearch. Following the war many new VA hospitals were built near or adjacent to medical centers. This paid dividends because the VA is now the largest training ground for colleges and universities in preparing students at the professional level for the medical field.

More than 16,000 such students now spend part of their time in VA hospitals and clinics.

What do these students do? The institutions are affiliated with 75 of the nation's 85 medical schools; 32 of the 47 dental schools; all of the 56 accredited schools of social work; the 58 approved universities for graduate training in clinical and counseling psychology; about 10 per cent of the schools of nursing; and with 127 schools providing training in physical medicine and rehabilitation.

In return for the affiliation the VA hospitals and clinics get the benefit of having visiting faculty members and the latest medical knowledge. The end result is an increase in the quality of medical care for our veterans.

ULCER CHAIN

Metropolitan Life Information Service tells us that 14 persons of each 1,000 population in the United States suffer from peptic ulcer. If all these craters were laid end to end, what a chain of lakes they would make.

RISK NO GREATER IN MULTIPARAS

Grand multiparas are women who have had seven or more babies. The incidence of complications of pregnancy and delivery was no greater in these women than in mothers with fewer babies. This information came from Haifa, Israel, where Drs. K. Fuchs and A. Peretz conducted a survey on 23,528 deliveries. Of this total 7.1 per cent were grand multiparas.

YES, WE KNOW

Motion picture producer Robert Cohn says that after months of studying, working, and talking with doctors and nurses in a dozen hospitals around the country, the most dramatic single place in the world is a hospital.

"There is more minute-to-minute drama in a hospital than any place I've ever known," the producer observes.

Cohn, who is currently producing "The Interns" for Columbia Pictures release, has been working on the project for over two years, since the best-selling book by Richard Frede was first published.

"I've been in the picture business all my life,"

he says, "and people think of it as a pretty dramatic profession, but it is certainly no more exciting or stimulating than the day-to-day events . . . in our great medical institutions."

Mr. Cohn is saying what we all know. Medicine is the most interesting of all professions. This is the reason why we are physicians.

PREDICTING MEDICAL STUDENT PROGRESS

Many physicians with children interested in going to medical school are upset when the boy or girl has a low score on the Verbal + Quantitative Ability section of the Medical College Admission Test (MCAT). The Association of American Medical Colleges recently compared 100 students with the highest Verbal + Quantitative scores with 100 with the lowest. Almost nine out of 10 students in the higher MCAT group (87%) made regular progress. Only one in 20 failed. Only two thirds (67%) of the low group made regular progress, and one out of six was an academic failure. Withdrawals for reasons other than failure accounted for three to four per cent of the students in both groups.

From this it is obvious that the MCAT score is an important indication of how the student will perform in medical school. There are exceptions in that 13 per cent of the low scorers were in the upper third of their first year classes. Many made regular progress and also excellent grades. On the other hand, 52 per cent of the high MCAT students were in the upper third, whereas only one in ten fell into the lower third. Some of these talented students did so poorly that they were dropped.

PHYSICIANS PROMOTING "SELF-HELP"

The national defense committee of the American Academy of General Practice urged its 27,000 members to take an active part in medical "self-help" training programs developed by the United States Public Health Service. These programs emphasize civil defense and disaster medicine. The academy's national headquarters in Kansas City, Mo., will distribute national defense materials and otherwise aid members in communities wishing to set up local defense committees.



Atlas of Obstetric Complications. Frederick H. Falls, M.D., and Charlotte S. Holt. \$40. Pp. 708. Philadelphia, J. B. Lippincott Company, 1961.

This is a monumental work of over 700 pages printed on 8½ by 11 inch quality paper. The senior author has had 50 years of clinical experience in his specialty. The junior author is a professional medical illustrator and sculptor eminently qualified in her field. The preface states, "We have attempted to set forth clearly in drawings and texts the concepts of the senior author based on 50 years of intimate contact with these problems." The text is brief and terse. It adheres strictly to Dr. Fall's views on etiology, diagnoses, and therapy.

Among special virtues of this volume is exactness of the reproductions to anatomy and clinical entities. There are 16 pages of Table of Contents for the 13 chapters. There are 708 illustrations on 599 figures, which include 250 color overlays. Some 220 of the illustrations are reproduced from the original medical sculptures and plastic carvings. One finds 62 full-color illustrations on 31 pages and, in addition, 23 full-color pages. Use has been made of "sepia" to emphasize clinical import.

This work represents a program of education and teaching developed over a number of years. The wealth of "visual aid" teaching material is now in printed form. It is the untiring drive of such teachers that explains in part the successful conquest of diseases and complications due to or associated with pregnancy and delivery. Dr. Falls and Miss Holt have produced an unmatched encyclopedic volume. This is a first of its kind and will likely be the only one for some time because of its superiority.

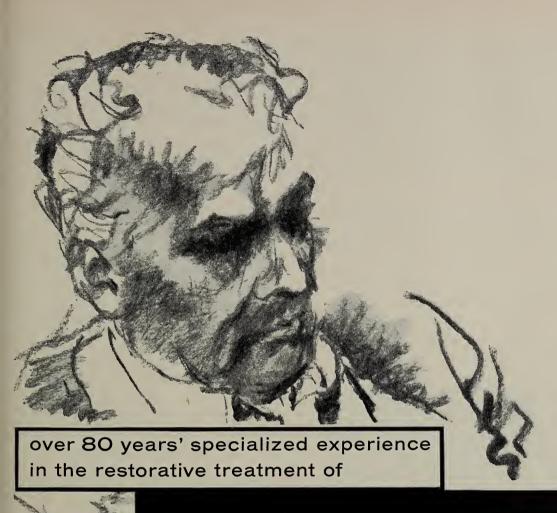
H. Close Hesseltine, M.D.

THE STAGES OF HUMAN DEVELOPMENT BEFORE BIRTH, AN INTRODUCTION TO HUMAN EMBRYOLOGY. E. Blechschmidt, M.D. \$23. Pp. 684. Philadelphia, W. B. Saunders Company, 1961.

Since the appearance of Kollman's Handatlas der Entwicklungsgeschichte des Menschen in 1907, no serious attempt has been made to cover this field. At that time early human stages were largely unresolved, so that lower forms served as substitutes. At present the only gap is the actual union of human sex cells; hence a new atlas, based wholly on human stages, meets a real need. An enormous amount of labor by the author, his graduate students, and other collaborators has gone into this atlas which, in its scope, exceeds greatly all previous counterparts. Its illustrations also excel in faithful detail, rather than being smooth approximations.

The stages covered are largely those of the first two fetal months, since in that period almost all of the organs make their appearance but, where needed, older stages are introduced - even to full term. The illustrations include total views, reconstructions, dissections, and microscopic sections in order that a fully rounded developmental series may be depicted. Emphasis is placed on growth directions and the mechanics of form development. Both the interrelations of organs and the individual differentiation of each are presented. The descriptive matter in German and English occupies parallel columns. The key-lists of names to numbered parts are also in both languages. There is a valuable list of references to the general and special literature, and there are two indexes.

This atlas is destined to become a classic source of reference. No other so ambitious has



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been attempted in the past, and no one in the foreseeable future is likely to enter into competition. It can be highly recommended to all who are interested in the general and detailed development of the human body. The subtitle is somewhat misleading; the book is not an "introduction" in the sense of being aimed at beginners in the study of embryology.

Leslie B. Arey, M.D.

A Manual of Cutaneous Medicine. Donald M. Pillsbury, M.D.; Walter B. Shelley, M.D., and Albert M. Kligman, M.D. \$9.50. Pp. 430. Philadelphia, W. B. Saunders Company, 1961.

This small book is a good one for it is authoritative, well written, and up-to-date. In addition, there are numerous well-selected photographic illustrations. Its scope is limited to the common conditions, those which, in the authors' experience, comprise about 90 per cent of clinical dermatology: the infections, dermatitides, drug eruptions, tumors, etc. In dermatology, as in other specialties, there has been during the past 20 years intensive study of the fundamental aspects of skin diseases, particularly of physiology, biochemistry, and anatomy. An excellent section briefly summarizes and assesses these developments in a way that is easily understood, and to read it is to understand more clearly the genesis of dermatologie disease. Therapy is considered in the same vein, with assessment of the usefulness and hazards of frequently employed treatment measures. Finally, an attempt is made to simplify the terminology — a measare that will be welcome and useful to nondermatologists, if not to dermatology itself. As a manual, it is recommended highly.

Herbert Rattner, M.D.

Introduction to Anesthesia, The Principles of Safe Practice. Robert D. Dripps, M.D., James E. Eckenhoff, M.D., and LeRoy D. Vandam, M.D. \$8. Pp. 413. Philadelphia, W. B. Saunders Company, 1961.

This is the second edition of this book, but it is still an expansion of the first, and designed to be only an introduction to anesthesia. It is an outgrowth of a work privately printed in 1949 called "Organization and Procedure."

Countless details that cannot be found in general texts are passed on from one individual

to another by word of month, and much of the teaching of anesthesia is done in this way. A good deal of the material covered in this volume could be classified as being in this rather shadowy area. Included in this book are such major chapter headings as: (1) The Preanesthetic Period, (2) The Day of Anesthesia, (3) During Operation, (4) The Postoperative Period, (5) Resuscitation, (6) The Anesthetist as a Consultant, and (7) Special Topics such as Pulmonary Function, Instruction in Anesthesia, and Malpraetice.

One of the most important statements in this book is entitled "Dedication" and it reads as follows: "To Dr. I. S. Ravdin. A surgeon who recognized the need for the development of anesthesiology, and contributed to its growth with vigor and enthusiasm." There are not enough surgeons about whom this statement can be said.

John S. Lundy, M.D.

THE ORIGIN OF MEDICAL TERMS. Henry Alan Skinner, M.B. \$12.50. Pp. 438. Baltimore, Williams & Wilkins Company, 1961.

This book, written by a professor of anatomy of the University of Western Ontario, is the second edition. Since the first appeared in 1949, the author has had a Nuffield travel grant which enabled him to extend his researches in England. The book is aimed at the medical student and offers a bit more than a medical dictionary and much less than a medical text.

The American student-reader must keep in mind that the spelling is British, complete with diphthongs in such words as myxoedema. While the etymology is scholarly, the anthor has not kept up with modern terminology. Parkinsonism, for example, is used in the best medical publications for the older terms — Parkinson's disease, shaking palsy, and paralysis agitans; but Skinner doesn't mention it. Newer conditions like inborn errors of metabolism are not touched upon.

The medical student may find the volume useful for ready reference, as it is arranged alphabetically. He also may use it as a comparative medical etymology or as a quickie biography (with line drawings) of men who have contributed to medical developments.

T. R. Van Dellen, M.D.

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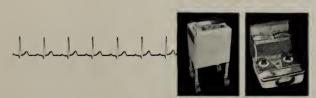
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*But please try to give at least three weeks' notice.



NEWS of the STATE



Adams County

Dr. Mortimer Brown, executive director of the Adams County Mental Health Clinic, has left his position to accept an appointment on the staff of Dr. Francis Gerty, head of the Illinois department of welfare in Springfield.

Cook County

New Medical Director

Michael Reesc Hospital and Medical Center has a new medical director, Dr. Abraham Gelperin of Kansas City, Mo. He succeeds Dr. Maurice A. Levine, who retired as medical director in September, 1961.

Dr. Gelperin comes from the Neurological Hospital in Kansas City, where he served as administrator and director of research and training since 1959.

He is a graduate of the University of Cincinnati Medical School and holds a doctorate in public health from Johns Hopkins University and a master's degree in hospital administration from Northwestern University.

Dinner Honors Drs. Palmer and Kirsner

Dr. Walter L. Palmer, Richard T. Crane Professor of Medicine emeritus, and Dr. Joseph B. Kirsner, professor of medicine at the University of Chicago, were the guests of honor at a January testimonial dinner. The dinner marked Dr. Palmer's retirement as head of the section of gastroenterology and Dr. Kirsner's appointment as his successor.

Dr. Morris Fishbein was toastmaster; others participating were Dr. Lowell T. Coggeshall, vice president of the university; Dr. H. Stanley Bennett, dean of the Division of Biological Sciences; and Dr. M. Edward Davis, chairman of the department of obstetries and gynecology.

Research Center at NU Opens

A clinical research center, staffed and designed for intensive study of patients with unsolved disease problems and conducted by Northwestern University Medical School and Passavant Memorial Hospital, was opened at the hospital in January. This initiates a \$2 million research program extending over seven years and supported by the National Institutes of Health.

Dr. Richard H. Young, dean, is principal investigator of the research program at Passavant, and Dr. David P. Earle, professor of medicine at Northwestern, is co-principal investigator.

The center, located on the third floor of the east pavilion of the hospital, contains accommodations for 14 patients, a special diet kitchen, three laboratories, a patient physiologic observation room, an external isotopic counting room, instrument room, offices, and utility facilities.

Clinical investigation will include projects already begun at Northwestern or Passavant. The greatest part of the research at present will be aimed at problems of diabetes, cancer, diseases of the heart, kidneys, and blood vessels.

Honors Bestowed

The American College of Radiology conferred its gold medal upon Dr. Earl E. Barth, Chicago, at a February 8 convocation for "distinguished and extraordinary service to the . . . College . . . and the profession . . ." Dr. Barth is president of the American Roentgen Ray Society.

Dr. Stephen Rothman, professor emeritus of dermatology and syphilology, University of (continued on page 195)



Number 28

Cook County

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Beachview Convalescent Home, Inc. 6345 N. Sheridan Rd.

Beckwith Nursing Home 3240 W. Washington Blvd.

Bell Nursing Home 11079 Bell Ave.

Belmont Rest Home, Inc. 1936 W. Belmont Ave.

Bigley Nursing Home 504 W. Wellington

Birchwood Beach Convalescent Home No. 1 7350 N. Sheridan Rd.

Birchwood Beach Convalescent Home No. 2 7364 N. Sheridan Rd.

Brown's Convalescent Home, Inc. 1900 S. Kedzie Ave.

Bryn Mawr House 6141 N. Pulaski Rd.

Burke Nursing Home I1840 S. Western Ave.

Burnside Rest Home 9435 S. Langley Ave.

Carmen Manor 1470 W. Carmen Ave.

Coleman and Cobb Nursing Home 4533 W. Washington

Colonial Towers Nursing Home 6032 Kenmore

Cordia Harmon Nursing Home 6463 S. Kimbark Ave.

Davis Nursing Home, Inc. 725-29 Waveland Ave.

Dearborn House, Inc. 2400 S. Dearborn St.

Douglas Nursing Home 3238 W. Douglas Blvd.

Doyle's Nursing and Convalescent Home 9626 S. Vincennes Ave.

Edgewater Manor 5838 Sheridan Rd.

Elizabeth Olivia Home 3952 S. Ellis Ave.

Elsa S. Long Convalescent Home 5250-5256 N. Sheridan Rd.

Englewood Rest Haven, Inc. 7253 Yale Ave.

Farwell Beach Convalescent Home, Inc. 1145 W. Farwell

Feinstein's Nursing Home, Inc. 5960 N. Sheridan Rd.

Fitch Nursing Home 11410 S. Forrestville

Fullerton Convalescent Home, Inc. 1400 W. Monroe

Garden View Home, Inc. 6450 N. Ridge Ave.

Garfield Nursing Home 3834 W. Washington Blvd.

Georgian Manor Rest Home 5726 N. Sheridan Rd.

Golden Age Home 4542 N. Malden St.

Granville Manor 1021 Granville Ave.

Greenview Rest Home 7225 N. Greenview

Hampden Manor 2724 Hampden Ct.

Hanson Nursing Home 7240 Jeffery Blvd.

Harmon-Bragg Nursing Home 6455 S. Kimbark

Hastings Nursing Home 7241 S. Princeton Ave.

Hearthside Nursing Home, Inc. 1223 W. 87th St.

Hollywood Convalescent Home, Inc. 1054 W. Hollywood

Homan Manor, Inc. 323 S. Homan Ave.

Howard Convalescent Home, Inc. 6522 S. Harvard

Hulda Johnson Home 7338 Stewart Ave.

Ivory Nursing Home 5839 S. Calumet Ave.

Jewish Peoples Convalescent Home 1522 S. Albany

Johnson Nursing Home, Inc. 3321 W. Fulton Blvd.

Kedzie Manor No. 1 3234 W. Washington Blvd.

Kedzie Manor No. 2 3230 W. Washington Blvd.

Ken-Rose Rest Home 6255 N. Kenmore

Kenmore House 5517 N. Kenmore

Kimbark Nursing Home 6132 S. Kimbark Ave.

Kostner Manor 1617 N. Kostner Ave.

Lake Shore Nursing Home, Inc. 7230 N. Sheridan Rd.

Lakeside Nursing Home 6330 N. Sheridan Rd.

Lakeview Manor Rest Home 2824 N. Sheridan Rd.

Lehrer Nursing Home, Inc. 4636 N. Beacon

Lincoln Park Home 2042 N. Orleans St.

Linderman Nursing Home, Inc. 3311 W. Monroe St.

Mahon Manor Nursing Home 7618 N. Sheridan Rd.

Malden Nursing Home, Inc. 4616 Malden Ave.

Manor Convalescent Home, Inc. 6401 S. Peoria St.

Maple Nursing Home 4743 W. Washington

Mark Howard Home 4938 S. Drexel Blvd.

Marquette Manor No. 1 6658 S. Harvard

Marguette Manor No. 2 6629 S. Harvard

Martha Washington Manor, Inc. 4515 S. Drexel Blvd.

Marx Nursing Home 6166 N. Sheridan Rd.

Melbourne Convalescent Home 4625 N. Racine Ave.

Midwest Home 310 S. Hamlin Ave. Miller Nursing Home 3256 Douglas Blvd.

Misericordia Home 2916 W. 47th St.

Monterey Convalescent Home 4616 S. Drexel Blvd.

Monterey Convalescent Home 1919 S. Prairie Ave.

Montgomery Convalescent Home 2735 S. Prairie Ave.

Mortkowicz Kosher Nursing Home 4851 N. Rockwell

Mt. Pisgah Nursing Home 4220-28 S. Champlain

Nesbitt Home 943 W. Foster Ave.

North Shore Rest Haven, Inc. 7428 N. Rogers Ave.

Oaden Park Convalescent Home 6617-25 S. Racine

Panenka Nursing Home 1901 S. Lawndale Ave.

Park House 2320 S. Lawndale Ave.

Patterson Convalescent Home 3242 W. Maypole Ave.

Peyton Convalescent Home 4541 S. Michigan Rabbi Meisels Convalescent

Home, Inc. 4900 Bernard St. Radtke's Beverly Hills Nursing Home

10347 S. Longwood Dr. Rhodes Nursing Home 3221 W. Washington Blvd.

Royal Manor 5640 N. Sheridan Rd.

St. Michael's Rest Haven, Inc. 4815 S. Drexel Blvd.

Schiller Rest Home, Inc. 1428 W. Jarvis

Shorecrest Convalescent Home, Inc. 7331 N. Sheridan Rd.

Shore View Momor Convalescent Home, Inc. 2719 E. 75th St.

South Shore Kosher Rest Home, Inc. 7325 S. Exchange Ave.

Sovereign Kosher Homestead 6224 N. Kenmore

Sovereign Kosher Rest Home 6159 N. Kenmore

Starnes Nursing Home 4155 S. Lake Park Ave.

Stern's Convalescent Home, Inc. 730 Waveland St.

Stewart Nursing Home, Inc. 6710 S. Stewart Ave.

Sunnyside Nursing Home 4537 N. Greenview Ave. Sunset Convalescent and Nursing Home 7270 South Shore Dr.

Thorndale Manor 1020 Thorndale Ave.

University Nursing Home 4750 S. Woodlawn Uptown Convalescent Home

4646 N. Beacon St. Victory Convalescent Home, Inc.

828 W. 35th Pl. Vincennes Manor, Inc. 4724 S. Vincennes Ave.

Virginia Cassidy Home

4502 Washington Blvd. Warner's Nursing Home

4401 Ellis Ave. Waveland Manor, Inc.

3662 Lake Shore Dr. Wendt Nursing Home

5914 N. Sheridan Rd. Westwood Manor, Inc. 2444 W. Touhy Ave.

Wincrest Nursing Home, Inc. 6326 N. Winthrop

Winston Manor Convalescent and Nursing Home, Inc. 2155 W. Pierce Ave.

Wrightwood Home, Inc. (Front) 504 W. Wrightwood Wrightwood Home, Inc.

(Rear) 504 W. Wrightwood

Chicago Helghts

Bel-Air Nursing Home No. 1 285 W. 16th St.

Bel-Air Nursing Home No. 2 309 W. 16th St.

Crestwood

Fraley Convalescent Home 4330 Midlothian Turnpike Rd. (P.O. Blue Island)

Des Plaines

Des Plaines Convalescent Home 866 Lee St.

Graceland Home of Des Plaines, Inc. 545 Graceland Ave.

Pine Tree Rest Haven

14201 S. Karlov Ave.

The Oak View 9555 Golf Rd.

Dixmoor

Dixmoor Villa Convalescent Home, Inc. Norris and Davis Sts.

Dolton

Dolton Manor Convalescent Home 14051 S. Lincoln Ave.





Miller's Rest Home 158th St. and Cottage Grove Ave.

Evansion

Asbury Home for Convalescents 1554 Asbury Ave.

Broad Nursing Home 2001 Orrington Ave.

Broad Nursing Home 1840 Asbury Ave.

The Evanston Nursing Home, Inc. 1304 Oak Ave.

The Evanston Rest Home, Inc. 1729 Livingston St.

Klingler Nursing Home 2306 Ridge Ave.

Pembridge House, Inc. 1406 Chicago Ave.

Ridge Crest Home 1708 Ridge Ave.

Evergreen Park

Bel Air Nursing Home 9307 S. Crawford

Evergreen Manor Nursing Home 3327 W. 95th St.

Peace Memorial Home 10124 S. Kedzie Ave.

Radtke's Nursing Home 2701 W. 95th St.

Gienview

The Glenview Convalescent Home 10320 Milwaukee Ave.

Whitehaven Acres Greenwood Ave. and Melody Lane Harvey

St. Jude Nursing Home 14660 S. Western Ave.

LaGrange

LaGrange Convalescent and Nursing Center 42 S. Ashland Ave.

Maywood

Lendino Nursing Home, Inc. 1110 S. 9th Ave.

Midlothian

Bowman Nursing Home. Inc. No. 1 3249 W. 147th St.

Bowman Nursing Home, Inc. 14743 S. Turner Ave.

Clover Acres 5252 W. 147th St.

Largent Convalescent Home 4323 W. I47th St.

Maple Farm Convalescent Home I4500 S. Long St.

Niles

Svithiod Nursing Home 8800 Grace St.

Oak Park

Oak Park Nursing Home, Inc. 637 S. Maple

Patterson Nursing and Rehabilitation Care 130 N. Austin Blvd.

The Woodbine 6909 W. North Ave.

Palatine

Bee Dozier Palatine Nursing Home, Inc. West Dundee Rd.

Catherine Memorial Home Meacham Rd.

Aage House 234 N. Plum Grove Rd. Plum Grove Nursing Home, Inc. 24 S. Plum Grove Ave.

Zielinski Nursing Home 95 W. Emmerson St.

Park Ridge

Parke Ridge Terrace 665 Busse Hgwy.

Prospect Heights

Weinert Nursing Home 511 Schoenbeck Rd.

Robbins

Sunshine Cottage Nursing Home 3421 W. 137th St.

Skokie

Old Orchard Manor 4660 Old Orchard Rd.

South Holland

Colonial Convalescent Home 549 E. 162nd St.

Stickney

Pershing Convalescent Home 6803 W. Pershing Rd.

Tinley Park

Kosary Convalescent Home 6660 W. 147th St.

The McAllister Nursing Home 18200 S. Cicero Ave.

Wilmette

Marie's Diet and Rest Home IOII Central Ave.

Worth

Rest Haven Illiana Christian Convalescent Home, Inc. 13259 S. Central

The assistance of the Division of Hospitals and Chronic Illness, Department of Public Health, State of Illinois is greatly appreciated.

In successive issues of the Journal the list of licensed homes by county will be completed.



(continued from page 190)

Chicago, has won a 1962 award for distinguished achievement from *Modern Medicine*. He was chosen for his work in relating the basic sciences to dermatology through demonstrations of the mechanisms of autonomic cutaneous axon reflexes and studies of melanin production and effects of sunlight on the skin.

Samuel B. Weiss, 35, University of Chicago biochemist, received in December the Theobald Smith Award for promising work by a young medical scientist presented by the American Association for the Advancement of Science.

The award was made for his work on deoxyribonucleic acid (DNA) and its relationship to other parts of the living cell.

Dr. George W. Beadle, chancellor of the University of Chicago and Nobel Laureate in medicine and physiology in 1958, and Dr. William C. Rose, professor of biochemistry emeritus at the University of Illinois, received Twentieth Anniversary Awards of \$1,000 and a citation from the Nutrition Foundation, New York, in December.

Dr. Beadle was honored for "fundamental discoveries of chemical and nutritional relationships in the science of genetics and for inspirational leadership in higher education."

Dr. Rose received his award for his "classic work in determining the adult human requirements for proteins, in terms of the individual amino acids, and for his notable record of training young scientists."

Psychiatric Institute Service Award

The Illinois State Psychiatric Institute at Chicago received the silver achievement award in the 1961 Mental Hospital Service Achievement Award contest of the American Psychiatric Association. The citation read in part, "Since its opening in July, 1959, the institute has become the keystone for the improvement of clinical services and for teaching and research programs within the 12 hospitals operated by the State Department of Mental Health."

(continued on page 202)

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Each pill is
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Clinical samples sent to physicians upon request.

Davies, Rose & Co., Ltd. Boston, 18, Mass, when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN

Often recurrent... often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.^{1,2} In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci." CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by Escherichia coli and Aerobacter aerogenes.3 In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent in vitro studies. 4-6

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, E. J., Jr.: Mil, Med. 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: Proc. Staff Meet. Mayo Clin. 34:187, 1959. (3) Ullman, A.: Delaware M. J. 32:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: Bull. Johns Hopkins Hosp. 108:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: Antibiotics & Chemother. 10: 694, 1960. (6) Lind, H. E.: Am. J. Proctol. 11:392, 1960.

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Literature available on request.

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for February, 1962



RO-CILLIN (phenethicillin potassium)—the preferred form of oral penicillin—is indicated whenever oral penicillin is called for.

Advantages: (1) higher blood levels, (2) effective in certain "G-resistant" infections, (3) dependable action—no known non-absorbers.

Ro-Cillin Oral Solution with its NEW, UNSUR-PASSED FLAVOR is the pediatric penicillin of choice.

Available as: 250 mg. tablets and 125 mg/5cc oral solution.

Side effects and precautions are the same as for penicillin G. Use with care where there is a history of allergy, especially to penicillin.

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provides broad-spectrum symptomatic relief of the common cold and other acute respiratory conditions, utilizing the well known synergistic effect of codeine and papaverine. Each yellow capsule (Rx only) contains:

Antitussive-analgesic: 16 mg. codeine phosphate, 16 mg. papaverine hydrochloride and 300 mg. aluminum aspirin.

Decongestant: 5 mg. phenylephrine hydrochloride Antihistaminic: 2 mg. chlorpheniramine maleate Plus 100 mg. Vitamin C to promote added resistance to infection.

Colrex Compound is rarely *contraindicated*—only in post-addicts to codeine and those with allergic reactions to opium alkaloids. *Side effects*, seldom encountered, include drowsiness, constipation and gastric distress.

For additional information, see your local Rowell man, or write:



Research Fund

Presbyterian-St. Luke's Hospital has received contributions totaling \$273,500 for research projects in the fields of gastrointestinal eancer and gastrointestinal allergy.

Mr. and Mrs. Robert A. Brown, Libertyville, gave \$173,500 to establish the Grant H. Laing Cancer Research Fund. The gift was for gastro-intestinal cancer research.

Dr. Grant H. Laing bestowed \$100,000 on the previously established Grant H. Laing Fund for the continuation of his studies in gastrointestinal allergy. Both projects will be conducted at the hospital.

M.D.'s in the News

Dr. Paul C. Bucy, professor of surgery at Northwestern University Medical School, has been elected to honorary membership in the Society of British Neurological Surgeons. . . . Dr. A. Beaumont Johnson, University of Illinois College of Medicine, has accepted an appointment as co-chairman for the Chicago area to help Baltimore's John Hopkins University raise \$12 million. . . . Dr. George G. Fischer, Wilmette, is the new treasurer of the American Rhinologic Society. Two Chicago physicians received committee appointments with the society: Maurice H. Cottle, Cottle Fund and chairman of education, and Roland M. Loring, education and chairman of nominating. . . . Dr. Edward Press, director of the Evanston City Health Department, has been appointed chairman of the Program Area Committee on Accident Prevention of the Illinois Department of Public Health.

Grants

A continuation grant of more than \$28,000 has been given to Northwestern University Medical School for a long-term study to probe what happens in the body during influenza and other severe lung infections.

Purpose of the study is to pin down in quantitative terms how the physiology of the body is disturbed during a severe infection. At present, very little is known about what happens to the function of the cardiovascular and pulmonary systems during attacks of influenza. Funds came from the USPHS.

Rotating Internship Program

This new program will begin July 1 at Chicago's Louis A. Weiss Memorial Hospital and will provide 12 rotating internships a year. Dr. Herbert Bessinger will be the director. The hospital will continue its existing approved general practice residency program in addition to the new plan.

Election:

St. Mary of Nazareth Hospital, Chicago, has elected the following Chicago physicians as its 1962 medical staff officers: Michael J. Kutza, president; Vincent J. Greco, vice president; Donald C. Wharton, secretary; and John F. Wiet, treasurer.

Lake County

Dr. Morley D. McNeal, Highland Park, had a surprise birthday party January 7 which probably ranked as the best in all his 70 years. He received a present with a future. Hundreds of friends and former patients gathered to do him honor and present his gift — a Dr. Morley D. McNeal Fund at the Highland Park Hospital to underwrite the cost of hospitalization for sick and needy children. The fund has been established with initial community contributions totaling \$9,000.

Madison County

Newly elected officers of the Madison County Medical Society for 1962 are Mather Pfieffenberger, Jr., president; Harry Mantz, president elect; Leo R. Green, secretary; and Henry Malench, treasurer. The state delegates are E. K. DuVivier and Eugene F. Moore; R. L. Holcombe and R. Greenwood are the alternate delegates.

Vermilion County

The county medical society's officers for the new year are Drs. Edward T. Baumgart, president; Stephen G. Baldwin, vice president; and Lewis W. Tanner, secretary-treasurer, all of Danville.

(News continued on page 210)



for February, 1962 207



Can we measure the patient's comfort?

The physician can measure the basal metabolic rate by means of oxygen consumption. But he has no instrument—no objective test—for measuring comfort.

For this, he must depend upon his own powers of observation and the patient's own description of how he feels.

Because these are, admittedly, subjective criteria, the validity of results hinges entirely on the experience and objectivity of the investigators involved.

Such well-qualified clinicians have reported that a new corticosteroid developed in the research laboratories of Upjohn actually raises the level of relief obtainable with this type of therapy.

This difference cannot be "proved." It must be seen. And the only practical way for you to do this is to evaluate this new drug critically in your own practice. Please do, at your first opportunity. We are confident that you will be glad you did.

The new corticosteroid from Upjohn research

Alphadrol

Each tablet contains Alphadrol (fluprednisolone) 0.75 mg. or 1.5 mg. Supplied in bottles of 25 and 100.

The anti-inflammatory activity of Alphadrol is comparable to the best effects obtained in current practice. Results obtained with Alphadrol have been such as to warrant classifying it among the most efficient steroids now available.

More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

Indications and effects

The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications

Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal in-

tolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

Winnebago County

The Winnebago County Medical Society recently conducted a poll of its members to determine their views of the organization. Two hundred and thirty forms went out, and 120 (52%) were returned.

Most members felt the society should be more active in the community and that a fulltime office and an executive with specific duties were essential.

A public relations program was strongly indicated, with newspaper articles and a speakers' bureau as the best broadcast media. Continued publication of the bulletin and weekly letter got mostly affirmative nods.

Suggestions worthy of note included an endowed speakers' program, stimulation of research, and compulsory attendance at certain meetings.

General

New Southern Regional Health Officer

Dr. Elvin Sederlin of Quincy is the new regional health officer for the Southern Region of Illinois (Region 5) with headquarters in Carbondale.

Dr. Sederlin, who has more than 21 years experience in public health positions, for the last five years has been health officer of the Adams County Health Department and, previously, of the Du Page County Health Department.

Counties which comprise Region 5 are: Monroe, Randolph, Jackson, Union, Alexander, Pulaski, Massac, Johnson, Williamson, Franklin,

Perry, Washington, Marion, Jefferson, Clay, Wayne, Hamilton, Saline, Pope, Hardin, Gallatin, White, Edwards, Riehland, Lawrence, and Wabash. Twelve of these have no local health departments.

Grants-in-Aid for 1961

State approval of grants-in-aid assistance to 20 applications for construction of hospitals and related medical care facilities in the state were given during 1961 under provisions of the Hospital Survey and Construction program.

Five were new general hospitals or additions to existing ones in Kankakee (St. Mary's and Riverside), Hinsdale (Hinsdale Sanitarium), Melrose Park (Westlake), and Rockford (Swedish-American).

Special category projects approved for grants were: four psychiatric units (two in Chicago, one each in Joliet and Urbana); two local health department buildings (Peoria and Quiney); two additions to dormitories for student nurses (Hinsdale and Chicago).

Additional special eategory projects included: two skilled nursing homes (Evergreen Park and Gibson City); two chronic disease units in hospitals (Joliet and Evanston); and three diagnostic and treatment units in these Chicago hospitals — Research and Educational, Presbyterian-St. Luke's and St. Joseph.

Centralia Institute Contracts Awarded

Contracts totaling \$11,401,416 for construction of the Mentally Retarded Institute at Centralia were awarded in January. Because the (continued on page 216)



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Medical Director

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(continued from page 210)

bids on the total project exceeded funds available for the work, a structure known as Ward Building 5 and kitchen equipment had been excluded from the contracts at a savings of \$1,104,300.

The Illinois General Assembly will be asked to appropriate funds to restore the building and equipment excluded.

Deaths

David Ackerman, Chicago, a graduate of Northwestern University Medical School in 1907, died December 3, aged 78. A Chicago physician for 54 years, he served on the medical staff of Chicago induction centers in World Wars I and II and was a staff member of Garfield Park Community Hospital, Oak Park.

ARTHUR W. ALLEN*, Robinson, a graduate of St. Louis College of Physicians and Surgeons in 1908, died November 18, aged 80. He founded the Allen Baptist Sanitarium in Robinson in 1912, was a director and vice president of the Second National Bank in the town, and in 1958 was named the Citizen of the Year there. He belonged to the 50-Year Club of the Illinois State Medical Society.

He practiced 53 years and had done graduate studies at the Mayo Clinic and the Crile Clinic, Cleveland.

Melvin F. Blaurock*, Oak Park, a graduate of the University of Illinois College of Medicine in 1935, died December 20, aged 52. He was certified in psychiatry and took graduate courses in military psychiatry. In 1935-36 he was a research fellow in psychiatry at the Institute for Juveniles and in 1939-40 was consultant at Hines VA Hospital. Dr. Blaurock also was on the staff of West Suburban Hospital, Oak Park, and director of the Oak Park Neuropsychiatric Clinic and the River Forest Health Resort. From 1942 to 1946 he was a lieutenant in the U.S. Army; he was a member of the American Geriatrics Society.

CLIFFORD L. CARTER, Ottawa, a graduate of the University of Illinois College of Medicine in 1932, died November 1, aged 54. He was president of the Ottawa high school board in 1953, a partner in the Ottawa Medical Center, and vice president and a director of the Ottawa National Bank. In 1933 he did graduate studies

at the University of Illinois College of Medicine, practicing in Ottawa since then, and at Columbia University in 1943. He was a staff member of Ryburn Memorial Hospital and surgical consultant at St. Joseph's Health Resort, Wedron. An Army Major in World War II, he was a fellow of the American College of Surgeons and was a former president of the Boy Scouts of America and holder of their Silver Beaver award.

ARTHUR E. DALE*, Danville, a graduate of Northwestern University Medical School in 1907, died December 8, aged 79. He practiced in Danville almost 50 years and was a former president of the Vermilion County Medical Society and the Wabash Valley Aesculapian Society. In addition, he was past chief-of-staff of St. Elizabeth and Lakeview hospitals and on the surgical staff of both as well as the Vermilion County Tuberculosis Hospital. For two years he was president of the Wabash Railway Surgeons Association and surgeon for that railroad, as well as the Chicago, Milwaukee, and St. Paul, and consulting surgeon for the Chicago and Eastern Illinois Railroad.

Dr. Dale studied in Europe in the 1920's and was a fellow of the American College of Surgeons and the International College of Surgeons.

Vernon C. David, retired, Evanston, a graduate of Rush Medical College in 1907, died November 15, aged 79. Formerly chairman of the surgical departments at Presbyterian and Children's Memorial hospitals, he was surgeon emeritus at Presbyterian-St. Luke's Hospital, and had been on the consulting staff at Presbyterian and Cook County hospitals.

Dr. David was a founder member of the American Board of Surgery and president from 1943 to 1945. Before retiring in 1952 he was clinical professor of surgery at the University of Illinois College of Medicine and was awarded honorary doctor of science degrees from Northwestern and Michigan universities. An emeritus member of the Illinois State Medical Society, he belonged to its 50-Year Club and was past president of the Chicago, Western, and American Surgical associations, and vice president and governor of the American College of Surgeons.

LEONILO T. DIGAL*, Saunemin, a graduate of the Chicago Medical School in 1940, died No-

Cook County Graduate School of Medicine Continuing Education Courses STARTING DATES-SPRING, 1962

Surgical Technic, Two Weeks, April 2, June 4
Surgery of Colon & Rectum, One Week, March 5, June 4
Advances in Surgery, One Week, March 19
Plastic Surgery of Head and Neck, One Week, April 9
Basic Principles in General Surgery, Two Weeks, April 23
General Surgery, One Week, May 7; Two Weeks,
April 2

Gynecology, Office & Operative, Two Weeks, April 9 Vaginal Approach to Pelvic Surgery, One Week, March

Obstetrics, General & Surgical, Two Weeks, March 12 Pain Relief in Childbirth, 3 Days, March 7 Proctoscopy & Sigmoidoscopy, One Week, March 26 Treatment of Varicose Veins, One Week, March 26 Basic Internal Medicine, Two Weeks, March 26 General Practice Review, One Week, May 21 Basic Electrocardiography, One Week, March 19 Gallbladder Surgery 3 Days, March 12 Surgery of Hernia, 3 Days, March 15 Urology, Two Weeks, April 2 Surgery of the Hand, One Week, April 16

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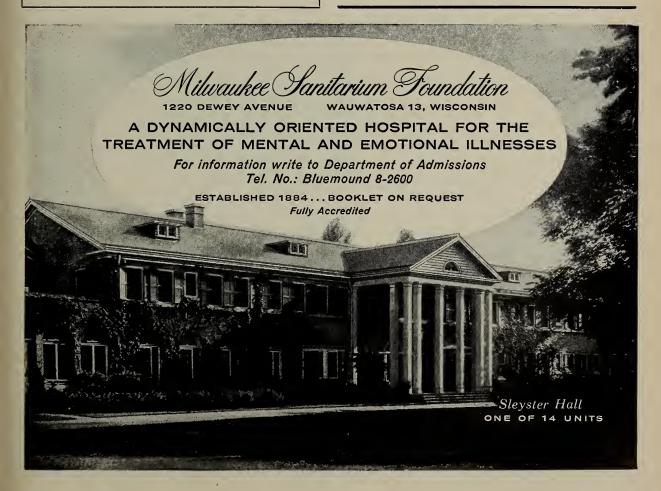
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vember 2, aged 53. He was president of the Livingston County Medical Society in 1959 and in World War II was a captain in the U.S. Army Medical Corps.

Walter R. Fischer*, Chicago, a graduate of the University of Illinois College of Medicine in 1920, died December 9, aged 67. Formerly head of the orthopedic department at Illinois Masonic Hospital, he was an attending orthopedic surgeon there. From 1921 to 1947 he taught at the University of Illinois Medical School and had been an associate on the staff of Cook County Hospital from 1933-47. Certified in orthopedic surgery in 1938, he was a fellow of the American Academy of Orthopaedic Surgeons and a member of the Clinical Orthopaedic Society.

ZENON S. HYBKE*, La Salle, a graduate of the Chicago Medical School in 1936, died August 18, aged 50. He was past president and on the executive and credentials committees at St. Mary's Hospital, La Salle, and belonged to the Illinois Academy of General Practice.

NATHAN IZBICKY*, Lincolnwood, a graduate of Univerzita Komenskeho Fakulta Lekarska, Bratislava, Czechoslovakia, in 1934, died November 16, aged 50. He was a member of the staffs of Walther Memorial and Illinois Masonic hospitals; a trustee of the Lincolnwood Jewish Congregation, and a past commander of Kirschenbaum Post No. 282, Jewish War Veterans, being honored as their Man of the Year in 1959.

L. OLIVE JAMES*, retired, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1913, died November 6, aged 89. For many years she had practiced jointly with her husband, Dr. Fred K. James.

OTTO L. Kahn, retired, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1907, died December 18, aged 81. A Chicago physician for more than 50 years, he retired from the staff of Wesley Memorial Hospital 15 years ago but continued in private practice until 1959. He served in the Army Medical Corps in World War I.

EVERETT C. Kelly*, retired, Peoria, a graduate of the University of Illinois College of Medicine in 1919, died November 17, aged 66. When he retired last May, he had practiced in Peoria 41 years. He was past president of the Peoria Medical Society and the St. Francis

Hospital medical staff, of which he was still a member.

ALBERT A. LE BEAU, Chicago, a graduate of the University of Illinois College of Medicine in 1910, died May 11, aged 73. He was a veteran of World War I.

REUBEN MARBELL*, Chicago, a graduate of the Chicago Medical School in 1937, died November 23, aged 57. A staff member at Central Community and Woodlawn hospitals, he practiced 25 years in Chicago.

EDWARD H. MARSHALL*, Clinton, a graduate of the University of Pennsylvania School of Medicine in 1912, died October 3, aged 75. He had emeritus membership in the ISMS.

James J. Marzullo*, Oak Park, a graduate of the Chicago Medical School in 1937, died January 7, aged 51. He was on the staff at Columbus Hospital.

AQUIL MASTRI*, Chicago, a graduate of the University of Illinois College of Medicine in 1929, died October 22, aged 58. He was a staff physician at St. Anthony de Padua Hospital.

Frank R. Maurer*, retired, Scottsdale, Ariz., a graduate of the Chicago College of Medicine and Surgery in 1916, died November 24, aged 74. He had been a staff physician at West Suburban Hospital and post surgeon for the Cicero American Legion before his retirement in 1958 after more than 40 years of practice. He was in the Army Medical Corps in World War I.

VAN A. McKinney, Chicago, a graduate of the Chicago Medical School in 1923, died December 8, aged 71. He was a physician in the U.S. government service for 48 years.

CLARK O. MELICK, Chicago, a graduate of Rush Medical College in 1923, died November 9, aged 75. He was a former assistant professor of preventive medicine at the University of Chicago and was on the staff at Illinois Central Hospital.

LUBERT B. MORRISON, Chicago. a graduate of the College of Physicians and Surgeons, Boston, in 1911, died June 25, aged 77.

EDWIN N. NASH*, retired, Galesburg, a graduate of Chicago Homeopathic Medical College in 1900, died November 20, aged 85. The first president of the Illinois Exchange Club, he had practiced 59 years and was an emeritus member of the ISMS and a member of its 50-Year Club.

(continued on page 220)

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HAROLD D. OMENS*, Chicago, a graduate of the Chicago Medical School in 1938, died November 15, aged 52. He was a staff member at Cook County, Mount Sinai, and Gottlieb Memorial hospitals and a member of the American Academy of Dermatology.

Anton J. Pok*, retired, Chicago, a graduate of Northwestern University Medical School in 1920, died December 12, aged 67. Before his 1953 retirement he had been a staff member of Evanston Hospital 34 years.

ORA A. RAWLINS, Chicago, a graduate of Rush Medical College in 1921, died November 6, aged 85. He had practiced in Chicago several decades.

HARRY C. ROLNICK*, Chicago, a graduate of Northwestern University Medical School in 1924, died December 9, aged 72. A staff member at Michael Reese and Mt. Sinai hospitals, he also was professor and chairman of the department of urology at the Chicago Medical School. In 1939 he was certified in urology and was a fellow of the American College of Surgeons and a member of the American Urological Association. He was an emeritus member of the ISMS and a member of its 50-Year Club.

EDWARD SAGER*, Chicago, a graduate of Northwestern University Medical School in 1922, died December 16, aged 65. He was certified in pediatrics in 1945 and was an associate in pediatrics at Northwestern University.

IRVING S. SCHIPPER*, Galesburg, a graduate of the Chicago Medical School in 1937, died November 15, aged 52. He was on the staffs of Cottage and St. Mary's hospitals.

WILLIAM J. SCHOLES*, Lanark, a graduate of the Chicago College of Medicine and Surgery in 1912, died November 23, aged 75. He taught pathology at Loyola for two years; in World War I he was a draft board examiner in Chicago, later serving as a first lieutenant in the U.S. Army Medical Corps, and in World War II was a draft board examiner for Carroll County. From 1933-35 he was president of the Carroll County Medical Society, secretary-treasurer from 1941-45, and in 1956 was elected an emeritus member. He also was an emeritus member of the ISMS.

HARLEY G. STANTON, East St. Louis, a gradu-

ate of the St. Louis University School of Medicine in 1912, died June 1, aged 74. He was a World War I veteran.

RANSOM VARLEY*, West Frankfort, a graduate of the Albany Medical College in 1943, died May 31, aged 44. A fellow of the American College of Surgeons, he was chief surgeon at Union Hospital and a captain in the U.S. Army Medical Corps Reserves from 1951 to 1953.

Bernard E. Walpert*, retired, Chicago, a graduate of Rush Medical College in 1903, died December 1, aged 85. For over half a century he practiced in Chicago until he retired three years ago. He was a life member of the American Medical Association, served on the staff of South Chicago Community Hospital 25 years, and was an emeritus member of the Illinois State Medical Society and belonged to its 50-Year Club.

Frank S. Weber*, retired, La Grange Park, a graduate of the St. Louis University School of Medicine in 1906, died November 18, aged 80. A member of the 50-Year Club of the Illinois State Medical Society and an emeritus member of the ISMS, he had practiced in La Grange over 30 years.

JOHN P. WOOD*, Quincy, a graduate of Rush Medical College in 1928, died November 17, aged 60. Certified in roentgenology in 1939, he was a staff radiologist at the Quincy Clinic, St. Mary's and Blessing hospitals, Quincy, and Community Hospital, Pittsfield, all since 1960. In 1957 he retired after 30 years as a captain in the Navy Medical Corps to practice in Quincy. As a medical officer Dr. Wood was a radiologist at naval hospitals in Philadelphia, Chelsea, Mass., Pearl Harbor, and Great Lakes. He had served as commanding officer of the medical supply depot at Oakland, Cal.; was chief of the professional division of the Bureau of Medicine and Surgery in Washington, D.C.: naval research medical officer in London, Eng.; commanding officer of the naval hospital at Charleston, S.C.; and district medical officer of the 10th naval district, New Orleans. He was a fellow of the American College of Radiology, a member of the Radiological Society of North America, and a diplomate of the American Board of Radiology.

^{*}Indicates member of Illinois State Medical Society.



The ILLINOIS Medical Journal

Clinical Articles

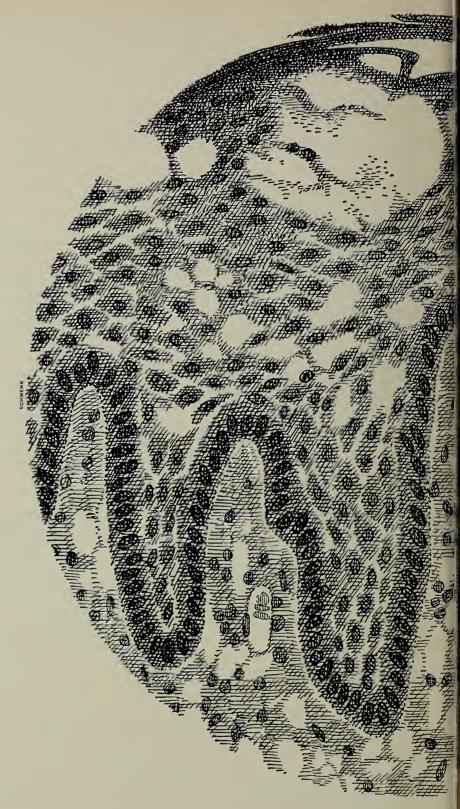
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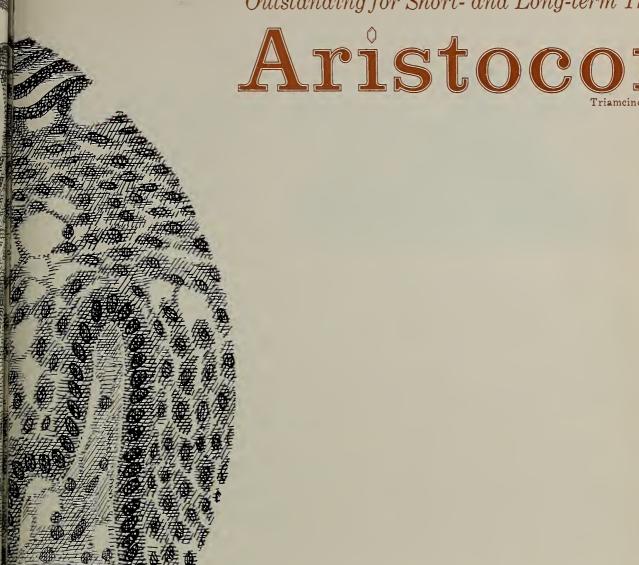
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I SEE IT FROM '360'

By ROBERT L. RICHARDS Executive Administrator

Correspondence and comments on my editorials in the "As I See It" column of the Journal are always welcome and appreciated. The following letter from N. Gillmor Long, M.D., Chicago, is timely and provocative regarding contact with congressmen on legislation affecting the practice of medicine. Let's have more of them.—Robert L. Richards.

Dear Mr. Richards:

Was most interested in your comments "As I See It from 360" relative to the need of constant "salesmanship" in combatting the threat of the first step toward medical socialization in the form of the King-Anderson Bill.

This is a provocative matter, from all angles, affecting not only organized medicine but every citizen and possibly his children's children. The Bulletin of the Montgomery County Medical Society, last year, had a sobering thought based on Social Security costs: "The present schedule calls for a gradual increase in the tax rate so that by 1970 it will be 9 per cent of the first \$4,800 earned. But this can be modified in any way, even to 20 per cent of \$10,000 by a vote of Congress.

"Anyone who entered this system in 1937 and has retired is receiving uncarned money. Those who are in it now will pay only about 40 per cent of the money they can draw out. But your children and mine, the ones starting today at 18 and 20, will pay 170 per cent of the value they receive! When they find out it costs much more than private insurance, what are they go-

ing to do? Well, they are going to modify the Social Security tax, or go all the way and make this a socialistic country where the government furnishes everything and everyone works for the government."

Now this is calculated on the Social Security tax as it now exists. It doesn't take much stretch of the imagination to postulate the costs, if the staggering estimate of the price of medical care to the aged is added to it. What a political football; as there is no country starting with care to the aged which hasn't ended up with care from the cradle to the grave, with the doctor's status shrinking to that of a paid state employee.

It is my opinion that it is not enough for the members of state medical societies to start and continue with a congressional verbal barrage, as important as it is. Each doctor has a concentric circle of devoted patients. My plea would be to have each doctor impress the seriousness of any measure carrying the threat of socialized medicine to all his patients both by letter as well as the powerful word-of-mouth media.

Possibly the Society could prepare samples of letters that could be used by patients to send to their congressional representatives. No one, but no one, can visit behind the scenes on Capitol Hill without realizing the paramount attention paid by each congressman to the barometer of public opinion reflected by the weather vane of his daily mail.

Respectfully submitted, N. Gillmor Long, M.D.

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For complete prescription information, including dosage, indications and precautions, consult product brochure.

References: 1. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958.

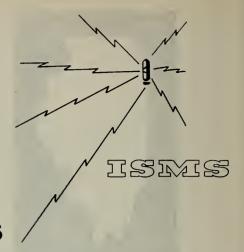
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Announcements

Cardiovascular Disease Symposium

The Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine are co-sponsoring the annual Symposium on Cardiovascular Diseases at the Brown Hotel, Louisville, Ky., March 28 and 29.

On the agenda are a panel on "Cerebral Vascular Diseases," a clinical-pathologic conference, and several supplementary films, in addition to the Monday night dinner meeting.

Medical History Lectures Coming Up

An invitation is extended to members and guests of the Society of Medical History of Chicago to attend an open meeting Wednesday, March 28 at 8 p.m. at the Institute of Medicine. The scheduled speakers are Dr. David B. Radner, professor of medicine, at the Chicago Medical School, "Intolerance of Great Men in Medicine," and Dr. Olaf K. Skinsnes, professor of pathology at the University of Chicago, "The Relationship Between Medical and Social Pathology of Leprosy in the Orient."

Summer Camp for Diabetic Children

The Summer Camp for Diabetic Children will be conducted for the 14th year under the auspices of the Chicago Diabetes Association July 15-August 5, at Holiday Home, Lake Geneva, Wis. Boys and girls 8 through 14 are eligible; rates are arranged according to individual circumstances. The camp will have a resident physician and nurse, two dietitians, and a laboratory technician, in addition to the regular counseling and domestic staff.

Address inquiries and application requests to the Association at 620 N. Michigan Ave., Chicago 11, or phone SUperior 7-8842.

Awards for Scientific Articles

Prizes totaling \$500 are being offered for the best original scientific articles published in Southwestern Medicine starting with the January, 1962, issue. The awards will be made in two classifications, regional and national.

Prizes in each classification will be awarded as follows: \$100 first prize, \$75 second, and \$50 third. The remaining \$50 will go to establish a fund for Intern and Resident Writing Awards.

The contest closes Sept. 1, 1962; articles should be submitted to Dr. Lester C. Feener, editor, 310 Stanton St., El Paso, Texas.

U.S. Hosts International Dermatologists

For the first time in 55 years the International Congress of Dermatology will be held in the United States. The seven-day assembly of specialists in dermatology from 37 countries will be presented in Washington, D.C., September 9-15, at the Shoreham and Shcraton Park hotels.

The five dermatologic organizations in the U.S. and Canada are hosts at the Congress. The sponsor is the American Academy of Der-

(continued on page 240)

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- relieves spasm

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Announcements (continued from page 238)

matology and co-sponsors, the American Dermatology Association, the AMA Section on Dermatology, the Society for Investigative Dermatology, and the Canadian Dermatological Association.

Sixteen symposiums will apply advances in basic sciences to clinical dermatology, supplemented by live, filmed, and televised case presentations, informal discussion groups, and exhibits.

Health Foundation to Move to Chicago

The Health Information Foundation, now located in New York, will move to the University of Chicago campus about April 30. Organized in 1950 as a non-profiit corporation by leaders in the drug industry, the foundation conducts research and education projects in the social and economic aspects of medical care.

It will operate as an administrative unit of the Graduate School of Business.

Illinois Nurses to Have Licenses Checked

A state-wide check of professional nurse licenses will be sponsored by the Illinois Nurses' Association during Nurses Week, March 18-24. The association also will explore ways in which professional nurses and community groups can work together to improve nursing care. Special emphasis will be placed on changes needed in the Illinois Nursing Act, which sets standards for nurse licensure and education.

PG Courses

Cook County Graduate School of Medicine announces a new series of short and intensive education courses for practicing physicians. In addition, a series of two and a half day Clinical Symposia will be presented Thursday, Friday, and Saturday mornings throughout the year.

The subjects and dates for the series are: "Surgery of the Neck," March 15-17; "Surgery of the Newborn," April 5-7; "The Problems of Aging," April 26-28; "Fluids and Electrolytes in Surgery," June 21-23; "Pediatrics," July 26-28; "Skin Grafting and Plastic Repairs," September 20-22; "Clinical Endocrinology," October 25-27;

"Newer Surgical Procedures," December 20-22.

For further information on courses or symposia address the Registrar, 707 S. Wood St., Chicago 12.

Sports-Medicine Newsletter Available

"Medicine in Sports," a newsletter containing the latest information on the care and prevention of athletic injuries, is now being distributed to all interested physicians as a professional service by the Rystan Company, Mount Vernon, N.Y. Requests should be directed to Charles Stanton, editor, c/o the Rystan Company, 7 N. MacQuesten Parkway, Mount Vernon, N.Y.

Pre-Residency Course in Ophthalmology

The Chicago Ophthalmological Society will again sponsor a six-month Basic Pre-Residency Course in Ophthalmology, beginning July 9, especially for graduates of accredited medical schools who intend to pursue residencies or preceptorships in ophthalmology. It will be presented at the Cook County Graduate School of Medicine in cooperation with the departments of ophthalmology of Chicago Medical School; Marquette, Northwestern, and Loyola universities; the University of Illinois, and various Chicago hospitals.

The curriculum will include related basic sciences, introduction to fundamental clinical subjects, the theory and use of ophthalmologic instruments, and essential laboratory disciplines.

Registrations will be limited. For further information address Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 12.

Jottings on Meetings

A 25-lecture program supplemented by 152 scientific exhibits has been prepared for the annual Scientific Assembly of the *American Academy of General Practice* April 9-12 at the Flamingo Hotel in Las Vegas.

Symposiums and panel discussions will range from geriatrics, orthopedies, pediatrics, and diabetes to artificial prolongation of life, undetected murder, electronics in medicine, and (continued on page 243) Announcements (continued from page 240)

avoiding malpractice suits. The president's reception and dance will be the night of April 11. A program for wives of academy physicians is also provided.

The complete program may be obtained from the Academy at Volker Blvd. at Brookside, Kansas City 12, Mo.

The third Midwestern Sectional Meeting of the *Biological Photographic Association* will take place in Des Moines, April 6-8, at the Downtowner Motor Inn.

"Technics Symposium" on slide preparation is one of the scheduled scientific papers by photographic specialists in medicine, dentistry, biology, and other sciences. A salon of color and black-and-white photographs will feature award-winning displays of clinical and specimen photography, photomicrography, and natural science; outstanding biomedical movies and a demonstration of animation technics also may be viewed.

All medical assistants are invited to attend the annual convention of the *Illinois Medical* Assistants Association April 27-29 in Quincy.

An Orthopedic and Rehabilitation Seminar will be held Saturday, March 31, at the Younker Memorial Rehabilitation Center in Des Moines. Three visiting out-of-state speakers are included in the program.

The Gill Memorial Eye, Ear, and Throat Hospital announces its annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties April 2 through 6. For details write the Superintendent, P.O. Box 1789, Roanoke, Va.

The ninth Congress of the Pan-Pacific Surgical Association will meet November 5-13, 1963, in Honolulu, Hawaii, and the first Pan-Pacific Mobile Educational Lecture Seminar will convene Nov. 13 through Dec. 10, 1963, in New Zealand, Australia, Thailand, the Philippines, Hong Kong, and Japan.

The seminar through the Pacific area offers, for the first time, scientific meetings in each country presenting medical material unique to the areas.

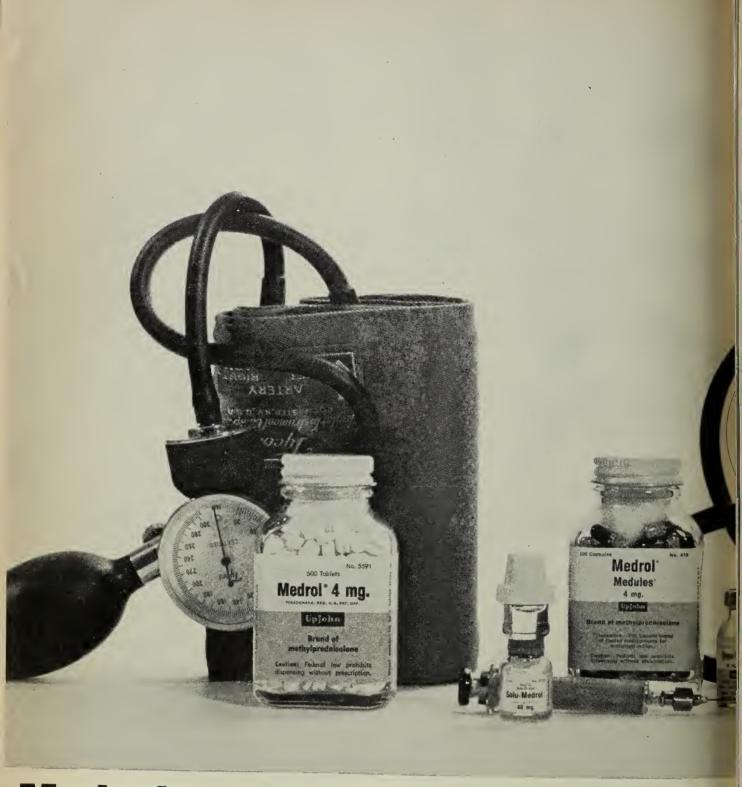
For details write Dr. F. J. Pinkerton, director general, Pan-Pacific Association, Suite 570, Alexander Young Building, Honolulu 13.

Nationwide plans to hold conferences in 1962 on obstetrie, gynccologic, and neonatal nursing were discussed at a November meeting sponsored by the American College of Obstetricians and Gynceologists.

In 1962 physicians in all eight districts of the college plan to hold meetings for their nurses. District VI, Chicago, will meet September 12-14.

Clinics for Crippled Children

- April 4 Alton (Rheumatic Fever) Alton Memorial Hospital
- April 4 Hinsdale, Hinsdale Sanitarium
- April 4 Rock Island (Cerebral Palsy) Foss Home, 3808 - 8th Avenue
- April 5 Cairo, Public Health Building
- April 5 Flora, Clay County Hospital
- April 6 Chicago Heights (Cardiac) St. James Hospital
- April 10 East St. Louis, St. Mary's Hospital
- April 10 Peoria (General) Children's Hospital
- April 11 Champaign-Urbana, McKinley Hospi-
- April 12 Springfield (General) St. John's Hospital
- April 13 Evanston, St. Francis Hospital
- April 17 Belleville, St. Elizabeth's Hospital
- April 17 Quincy, Blessing Hospital
- April 18 Chicago Heights (General) St. James Hospital
- April 19 Elmhurst (Cardiac) Memorial Hospital of DuPage County
- April 19 Rockford, Rockford Memorial Hospital
- April 24 Effingham (Rheumatic Fever) St.
 Anthony Memorial Hospital
- April 24 Peoria (General) Children's Hospital
- April 25 Aurora, Copley Memorial Hospital
- April 25 Springfield (Cerebral Palsy P.M.) Memorial Hospital
- April 26 Bloomington (General A.M.) St. Joseph's Hospital
- April 26 Mt. Vernon, Masonic Temple
- April 27 Chicago Heights (Cardiac) St. James Hospital



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The ILLINOIS Medical Journal

Official Journal of the Illinois State

N N

Medical Society

March, 1962

Volume 121, No. 3

Topical Treatment in Rheumatic Disease

EUGENE F. TRAUT, M.D., F.A.C.P., H. PAUL CARSTENS, M.D., Associate A.C.P., CHESTER B. THRIFT, M.D., and HARRIET M. CLARK, M.D., Chicago

It is Instinctive to apply the hand to a painful part of the body and then to move the hand over the painful area, thus performing massage. The benefits of massage are universally acknowledged. The increased circulation and the analgesic effects have been amplified by addition of heat produced mechanically or chemically. Medicaments rubbed into the skin over the joints, muscles, ligaments, and tendons in the diseases grouped as "rheumatic" have had rubefacient or, hopefully, specific antirheumatic results.

Liniments and salves are in the group of folk medicines still widely employed for rheumatic and pararheumatic complaints. No publications regarding local application of antirheumatic remedies have appeared for many years in the Surgeon General's Catalogue¹ or the Quarterly Cumulative Index. Nevertheless the March, 1956, issues of the Annals of the Rheumatic Diseases² devoted seven of its 18 largest advertisements to liniments or salves. A recent text advises using various advertised liniments for the relief of joint inflammation

and fibrositis.³ Druggists report lively "overthe-counter" sales of liniments, their sales amounting to at least hundreds of thousands of dollars yearly. This popularity of the local treatment of rheumatism is contrasted with the scarcity of recent literature and scientific studies of this popular therapeutic arm.

Liniments enjoy the blessings of abundant precedents. Medicines were applied to the skin, to a greater extent than internal medication, to relieve man's suffering before the time of Hippocrates and by Celsus and Galen. Only recently has massage, a form of therapy practiced by the ancients, been reaccepted as a valuable agent.

When medicines are applied locally, it is debatable whether their effect on underlying inflammation is due to the salicylate on the skin, to its absorption and consequent systemic action, to the massage accompanying the application, and/or to a placebo effect.

We became interested in comparing the effects of an emollient containing medicaments with a placebo control of a bland, unmedicated salve. We also wished to further control the topical application by employing it only on patients previously tested for suggestibility by oral and injected placebos.

From the Cook County Arthritis Clinic, the Hektoen Institute for Medical Research, and the University of Illinois College of Medicine

Description of Patients

Patients treated with ointment numbered 146. Those with degenerative arthritis (98) were more than three times as numerous as the patients with rheumatoid disease (25) (Table 1). Seven patients had fibrositis unassociated with clinical joint disease; three patients had chronic gouty arthritis, and one had psoriatic arthritis. Females outnumbered males 3 to 1. This female preponderance was maintained in the ratio of females with rheumatoid disease (Table 2). The sex of the fibrositis patients followed the over-all ratio. Negro patients comprised 70 per cent of the whole. Patients included young women with rheumatic arthritis to octogenarians with degenerative disease. Thus, most of our patients were colored women between 30 and 60 years of age, usually obese and with degenerative joint disease. The ethnic groups showed no difference numerically in the sex or rheumatoid-degenerative proportions. All of our patients were ambulatory but too ill to work. The rheumatoid patients were usually moderately or severely afflicted (Class 2 to Class 4, A.R.A.). Only two patients with degenerative arthritis required wheel chairs or crutches. Of the patients with degenerative arthropathy 39 had mild manifestations (1 or 2 joints, discomfort rather than pain severe enough to hinder sleep or work), 58 had more and yet moderate signs (several joints, enough to prevent work or cause invalidism). Thus, over half of the patients with degenerative arthritis were moderately incapacitated, and onethird of them had mild disability. In most of our patients the degenerative joint disease involved the spine. The next most frequent site was one or both knees.

Method of Study

The patients were veterans in rheumatic disease therapy. Before coming to our clinic they had run the gauntlet of all the currently used chemical and physical agents, including the use of massage and various modalities of heat. All of the patients had been exposed for an adequate period of weeks to (1) an oral (lactose) and (2) an injected (NaCl) placebo.⁴⁻⁶ The 146 patients in the Arthritis Clinic of the Cook

Table 1. Kind of Arthritis of the 146 Patients
Treated with Ointments.

Degenerative	98
Rheumatoid	25
Others	23
Total	146

Table 2. Sex and Race of 146 Rheumatic Patients Treated with Ointments.

	Ratio
Females to Males	3:1
Rheumatoid: Females to Males	3 : 1
Negroes to Whites	3:1

County Hospital were issued, on separate weeks, tubes containing a perfumed paste called A and tubes containing a medicated paste called B, similar in odor and appearance. The medicated salve contained esters of salicylic acid, nicotinic acid and benzoic acid in a water miscible base.* The patient did not know which salve was medicated. He was told to rub the salve into a designated area for five minutes nightly for seven nights. Usually the patient was instructed to treat one joint, preferably the most painful, using the corresponding inflamed joint on the opposite side of the body as a further control. He then reported the results to the clinic. The terms ointment, salve, liniment, and preparation are used synonymously. Twenty-one patients were given two trials with each ointment, the placebo and medicated, alternately. The results were appraised by any of a group of experienced rheumatologists.

Results

Both symptoms and freedom of motion were favorably altered with surprising frequency and to a marked degree by the bland as well as by the medicated ointment. The results were evaluated in relation to the kind of rheumatic disease treated, the sex and color of the patients, the severity of the presenting disease, and the degree of relief, if experienced. Such easily available criteria as relief of pain, partic-

[°]Transvasin®, Carter Products

ularly night pain and pain on motion, stiffness, swelling and tenderness of the part, received especial attention. The effects of the placebo and medicated salves were compared.

Results were classified as successes or as failures. Either or both ointments were judged clinically successful in 142 patients (Table 3). The medicated preparation (B) was definitely helpful subjectively, objectively, or both, in 142 patients. The subjective benefits exceeded the improvement in findings. A gave more relief than B in 27 patients, and A equalled or surpassed B in relief of 60 patients. Both preparations were equally beneficial to 33 patients. B was more effective in the less severely ill patients, relieving patients mildly, moderately, or severely disabled in the ratio of 7:5:1. The patients finding A equally or more effective were classifiable as having only moderate disability.

Eighty-three patients enthusiastically reported the benefits from B over A (approximately 3:2). Some preferred B because it was "hotter." Relief was felt progressively during the rubbing-in of the ointment. The relief lasted usually a few hours, occasionally a week or more. One of the three patients with chronic gouty arthritis was benefited by the medicated preparation. The patients deriving no benefit from either the medicated or placebo preparation were males and white. This might warrant the assumption that this group of patients was more critical, even skeptical.

The only unfavorable reactions were transient rashes following use of the placebo as well as the medicated ointment. The rashes disappeared within 48 hours.

The 142 patients benefiting from the medicated or both ointments were required to compare ointment benefits with the effects of previously used placebo controls (lactose tablets and saline injections) (see Methods of Study). Four patients claimed more relief of joint pain and stiffness and more general well being from placebo tablets than from either liniment. Of the 142 patients claiming benefit from ointments all were emphatic about the superiority of the saline injections to any other kind of treatment. All of the patients benefiting from the ointments wished to continue using them in combination with their previously beneficial procedures.

TABLE 3. SUCCESS OF TOPICAL TREATMENT AS REPORTED BY 146 RHEUMATIC PATIENTS IN STUDY.

Treatment	Rating	No. of Pts.
Medicated Ointment	Superior	83
Placebo Ointment	Superior	27
Both Ointments	Equal	33
Placebo Ointment	Equal or Superior	60
Both Ointments	No Benefit	4

Discussion

A liniment offers some advantages of ideal therapy. Contrasted with the imposing dangers of steroids, gold, or antimalarials, side effects of liniments are limited to skin irritation readily diagnosed and easily avoided or alleviated. The patient, usually applying this form of medical application himself, has a comforting sense of direct control to prevent over-stepping his pain threshold.

Until the last half century almost all treatises on rheumatic disease advocated liniments or salves to be applied to areas of stiffness and pain. These agents were called counter-irritants, rubefacients, or epispastics. They contained, in an oily or watery vehicle, varying amounts of irritants and salicylate and, more recently, histamine. Fantus describes the use of percutaneous histamine in the treatment of soft tissue "rheumatism." The skin, a nociperceptor, is richest in histamine. The histamine is released by mechanical and chemical stimuli of the skin to affect inflammations, even in distant organs, in a nonspecific manner. Turpentine, iodine, camphorated soap, chloroform, mustard, menthol, and ammonia have also been incorporated into bases for application over painful parts of the skeleton and its attachments.

The old principle of counter-irritation has been invoked to explain the benefits of liniments. Accordingly, inflammation produced superficially by chemical heat or electrical or mechanical trauma favorably influences underlying or even distant inflammation. Chemicals applied to the skin may be absorbed to produce systemic effects. We recall the gingivitis induced by mercurial ointments used in the treatment of syphilis. Radioactive iodine applied to the skin has been demonstrated in animal organs, including those of the fetus in utero.⁷

Clinical improvement tollowing the use of liniment can be broken down into the mechanical effect necessary to the method of application (massage and the chemical effect of the contained drugs — both irritant — producing vasodilatation) and the presumed antirheumatic effect of the salicylates. The local vasodilatation consequent to any preliminary heating, the massage, and menthol facilitate the absorption of the salicylates.

In 1938 the fall of liniments into disuse was deplored by Fantus. He called attention to the faith of the people in local treatment and its psychotherapeutic effects. He pointed out the greater likelihood of obtaining massage if some medicated substance other than a simple emollient were recommended.⁸ Today an almost apologetic explanation is usually given to the patient's query, "What shall I rub it with, Doctor?" Doubt and nonconviction are expressed on the face of the patient instructed to massage with mineral oil rather than an odoriferous liniment.

Certainly the placebo factor of linimentbenefits deserves frank recognition. The patient, or spouse, participating in the application of a liniment has a satisfying sense of doing something positive. The expense and fatigue of travel to a professional physiatrist are reduced or eliminated.

Salicylates have been used externally, as well as internally, at least as far back as 5,000 years ago. They were obtained from the willow. The salicylate was usually methyl salicylate (oil of wintergreen) or salicylic acid. Methyl salicylate has a local rubefacient action. One liniment (capsicum, methyl salicylate, camphor, oil of pine, eucalyptus, and turpentine) raised the temperature of structures 2.5 cm. below the skin three degrees centigrade in 40 minutes for four and a half hours when applied to the skin without rubbing. 11

Salicylates have been and are respected as the most effective and cheapest antirheumatic drugs. They are known to be absorbed through the intact skin. Salicylate poisoning, even fatal, has resulted from oil of wintergreen applied externally.^{12,13}

Spies again confirmed the absorption of salicylates through the skin by demonstrating them in the urine. He observed skeletal pain relieved by his liniment.¹⁴

Summary

One hundred forty-six ambulatory patients with various chronic rheumatic diseases were treated with a medicated salve and a placebo salve. One hundred forty-two of the patients and the attending rheumatologists considered either or both ointments helpful. The medicated ointment succeeded in only one-third more instances than the placebo. The placebo preparation failed to relieve twice as often as the medicated salve. Most of the patients preferred the effects of injected placebos to any other antirheumatic measures, including the liniments. Most patients asked to have liniment added to their previous medication.

The very large majority of patients and their relatives found great comfort from the local application of medicine. Their enthusiasm far exceeded that experienced from using any modality of physical medicine. Our experience strongly suggests the desirability of seriously incorporating liniments or medicated ointments or creams into the therapy of rheumatic disease.

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Piminodine As an Adjunct to Anesthesia

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PIMINODINE ETHANESULFONATE (Alvodine®) is a recently introduced narcotic analgesic drug with some pharmacological properties that led us to believe it might be a valuable adjunctive agent for both regional and general anesthesia. Several published reports on the clinical use of piminodine have indicated its value and safety.¹⁻⁵

Chemically the drug is related to meperidine, differing from the latter in that a 3-(phenylamino) propyl group replaces the methyl radical on the nitrogen of the piperidine ring (Fig. 1).

Pharmacologically, however, there are considerable differences. Piminodine is almost purely analgesic, lacking — when given alone — the side effects of drowsiness, respiratory and circulatory depression, nausea, and eu-

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phoria that are characteristic of many potent narcotics. The combination of piminodine with either barbiturates, general anesthesia, or potentiating drugs such as the phenothiazines may, however, produce some respiratory depression and also may cause "sleep." With piminodine the respiratory depression consists of merely slowing of rate with increased depth compensating to normal alveolar minute volume. The "sleep" is characterized by tranquility from which the patient is easily aroused and remains rational. Neither of these effects are typical of those produced by most other narcotics.

The current study was undertaken to determine the value of this drug given in small doses intravenously as a potentiator of light general or marginally inadequate regional anesthesia. The analgesic activity of piminodine has been studied by different methods in several species of animals.⁶

In a comparative evaluation in rats, it was shown that piminodine was approximately 1.5 times more potent than morphine. In dogs some degree of bradycardia and hypotension resulted when the animals were anesthetized. Hypotension did not occur, however, in the unanesthetized animals. Respiratory depression of a significant degree can be produced by the intravenous administration of the drug in the dog. This is readily reversed by the narcotic antagonists. Chronic toxicity studies have failed to show any untoward effects upon the viscera or blood forming organs.

Method of Study and Materials

This series is comprised of 232 unselected male patients ranging in age from 22 to 78 years (average 48.85) brought to the operating room at Hines Veterans Administration Hospital. They were classified preoperatively according to the American Society of Anesthe-

siologists' standard classification of physical status; 55.6 per cent were considered within class III to class VII, indicating moderate or severe physiologic impairment (Table 1).

A wide variety of surgical procedures was included as indicated in (Table 2).

The narcotic piminodine was used principally to supplement nitrous oxide and oxygen anesthesia previously induced with a short-acting barbiturate such as thiamylal sodium or thiopental sodium. An attempt was made to use minimal dosage of the narcotic to accomplish the over-all requirement of the surgical procedure. We emphasize that this technique is different from the apparently similar technique where a narcotic is employed as a primary anesthetic agent.

In a number of cases where inhalation agents such as ether, cyclopropane, and halothane were used (Table 3), piminodine was used to meet one or more of the following situations:

- 1. To maintain a light plane of anesthesia while providing a more potent analysesic effect, especially in poor risk patients.
- 2. When the surgical team desired the shift to a nonexplosive technique after the procedure had begun.
- 3. When for one reason or another an inhalation agent was inadequate to provide a smooth course of light anesthesia during surgery. This implies that it was felt preferable to utilize the minimum dosage of the fixed narcotic agent rather than increasing the flow rate of the inhalation agent, because the side actions from the narcotic were considered less hazardous than those of the volatile agent under these specific conditions.

The series also included various regional techniques using piminodine as a supplementary agent to meet one of the following situations:

- 1. When the regional agent and/or technique had failed to achieve adequate analysesia for the specific type of surgery.
- 2. When the patient showed signs that the regional agent was "wearing off" before the end of surgery.

These 232 patients are the number that have been studied and tabulated. However, in another section of this department, essentially an

Table 1. Classification of Physical Status of 232 Patients.

Class	No. of Cases	%
I	28	12.07
II	75	32.33
III	76	32.76
IV	19	8.19
V	2	0.86
VI	19	8.19
VII	13	5.60
Totals	232	100.00

TABLE 2. OPERATIVE SITES IN 232 PATIENTS.

•	Regional No. of Cases	General No. of Cases
Head and Neck	10	40
Thorax		39
Upper Abdominal	3	21
Lower Abdominal	6	10
Abdominal Wall	16	6
Perineum	4	
Spine	3	22
Extremities	10	42
Totals	52	180

TABLE 3. GENERAL TECHNIQUE IN 180 CASES.

Agents		nduction Maintenance Primary Primary		Maintenance Secondary	
N _o O	8	(4.44%)	161	(89.44%)	5
Tĥiamylal					
Sodium	76	(42.22%)			11
Thiopental					
Sodium	81	(45.00%)			
Ether			7	(3.89%)	2
Cyclopropane	10	(5.56%)	12	(6.67%)	6
Halothane	5	(2.78%))		16

equal number of cases have been performed in which the routine records were maintained, but no attempt has been made to tabulate and study these. Upon cursory examination, however, the impression gained is basically similar to the one in the present study. Furthermore, studies are being conducted on the use of piminodine on several hundred obstetrical patients in which the over-all conclusion has been confirmed.

Technique of Administration

Premedication. Patients were premedicated according to the anesthesiologist's preference and the requirement of each patient. Table 4 (A & B) shows the variety of agents utilized as well as the dosage employed in all the 232 patients.

Dilution and Dosage. Piminodine has been supplied, for the purpose of this study, in ampules containing 20 mg. The contents of the ampule was placed in a 10 cc. syringe and diluted to make a total volume of 10 ml. in a solution of one-quarter strength saline in 5 per cent dextrose. This diluent is the usual intravenous infusion routinely started in each patient in the operating room prior to the induction of anesthesia. Thus diluted, each milliliter contains 2 mg. of piminodine.

In those instances where piminodine was purposely chosen, regardless of the primary maintenance anesthetic agent to be used, an initial dose varying between 3 and 5 mg. (average 3.63 ± 0.08 mg.) was injected into the intravenous tubing. This was usually done immediately after venipuncture. The dosage of piminodine administered varied with the technique employed and the over-all effectiveness of the premedication. The time between this initial dose of piminodine and primary induction was roughly 5 to 10 minutes.

Subsequent doses of 1.0 to 3.0 mg. (average 2.0 mg.) were administered via the infusion during the rest of the procedure as required to maintain a smooth course.

Great emphasis was placed on recording significant data relative to the administration of the narcotic. An interval of three to five minutes was allowed after the introduction of each dose of piminodine.

In other instances where piminodine was not purposely chosen, but, as stated before, was used to meet specific situations during the course of either general or regional techniques, the initial dose, subsequent doses, method of administration, and procedure followed was basically the same as stated in the preceding paragraphs.

Findings and Discussion

Anesthesia Time: (The interval from the ini-

Table 4. Premedication of the 232 Patients in this Study.

A. Agents	Number of Cases
Morphine-Sulphate-alone	2
Morphine-Sulphate + Nembutal®	2
Demerol®-Phenergan®	124
Demerol-alone	27
Demerol-Nembutal	26
Demerol-Nembutal-Phenergan	1
Phenergan-Nembutal	10
Phenergan-alone	5
Nembutal-alone	3
Luminal®-Demerol	1
Phenazocine-Phenergan	5
Phenazocine-alone	1
Alvodine-Phenergan	2
NOTE: 1 00	71

NOTE 1. 23 patients received no premedication.

NOTE 1. 25 patients received no premedication.

NOTE 2. 158 cases—premedication considered satisfactory by anesthetist.

39 cases—was considered unsatisfactory by anesthetist.

12 cases—no determination.

NOTE 3. In 141 cases atropine sulfate was also utilized and in 53 cases scopolamine was used.

B. Dosage of Premedication

Dosage		Promethazine (Phenergan®)	
25 mg.	7	137	
50 mg.	84	10	4
75 mg.	77		
100 mg.	10		30
150 mg.			5
200 mg.			1

NOTE: Phenazocine when used in six cases was given in doses of 2 mg.

Alvodine when used in two cases was given in doses of 4 mg.

tial application of the primary induction agent to the discontinuance of all anesthetic agents.)

Average: 160.98 ± 5.75 minutes

Shortest: 18 minutes

Longest: 460 minutes (7 hrs., 40 min.)

Operating Time:

Average: 136.51 ± 5.39 minutes

Shortest: 10 minutes

Longest: 405 minutes (6 hrs., 45 min.)

Average Doses of Piminodine Initial: $3.63 \pm .08$ (base 4 mg.)

Total: 9.04 ± 0.30 mg.

In the average patient, once the initial dose of piminodine had been injected, the amount

of the short-acting barbiturate or inhalation volatile agent required for induction and for endotracheal intubation (where required) was greatly reduced. Usually the intubation was carried on after slow injection of a minimum dose of a thiobarbiturate (100 to 250 mg.) or application of an inhalation volatile agent, enough to make the patient close his eyes but without the customary waiting for the abolition of the eyelid reflex. Adequate muscle relaxation is provided for purpose of intubation by the injection of succinvlcholine (50 to 60 mg.); only in very rare instances did the patient demonstrate slight movement or straining, although blood pressure and pulse rate were maintained stable or showed a minimal increase.

It was found that once adequate anesthesia was established, the smoothness of the course was usually maintained by supplementing the primary agent with intermittent intravenous injections of 2 mg. of piminodine at intervals ranging from 40 to 50 minutes (average 45 min.). The average total dosage was 8 to 10 mg. for a 2 to 3 hour procedure.

Discussion

Our impression is that piminodine depressed the vagal type reflexes resulting from stimulation of the upper respiratory tract including pharyngeal, laryngeal, and tracheal reflexes. Though tracheal reflexes were obtunded, bronchoscopy required the addition of topical anesthesia. However, intubation of the trachea in the conscious patient was markedly facilitated as was laryngoscopy, so much so, that in a number of patients, direct laryngoscopy was performed 5 to 10 minutes after the intravenous injection of 10 to 20 mg. of piminodine without the utilization of topical anesthesia.

We stress that, when this technique is utilized for laryngoscopy, adequate sedative premedication is required. Respiratory depressants should be omitted or kept to the minimum for this purpose. When used alone in the conscious patient, marked respiratory depression was seldom encountered with doses from 10 to 20 mg. intravenously. However, when used in conjunction with agents having marked effect on the respiratory system (such as thiopental, thiamylal, halothane, and cyclopropane), respira-

tory depression occurs apparently in direct proportion to the amount of the depressant agent and the amount of piminodine used. Respiratory depression usually begins in two to three minutes, reaches its nadir in about eight minutes, and lasts 15 minutes or less unless controlled respiration is instituted and maintained. (It was found that this depression occurs at the expense of the rate with adequate compensation of depth so that minute volume is usually adequate.) In the majority of the cases where respiratory depression occurred, its degree was so minimal as not to be alarming. However, in the occasional case of marked respiratory depression during the administration of anesthesia, controlled respiration for a period of 15 to 20 minutes was instituted; the patient took over with adequate respiratory rate and minute volume at the end of this period. Respiratory depression may be prevented or counteracted, if desired, by appropriate use of minimal quantities of a narcotic antagonist. We have found that in all instances a single dose of 0.5 mg. I.V. of levallorphan (Lorfan®) was adequate.

Less than 7 per cent of all patients were administered the narcotic antagonist, and this was done in some instances primarily for evaluation purposes as well as clinical indications.

As a result of the administration of the narcotic antagonist, as with all of our previous narcotic-narcotic antagonist administration, an expected concomitant elevation in blood pressure occurred.

Where desirable, control of respiration can be accomplished with ease in lighter planes of general anesthesia by using piminodine as a supplementary agent. This was particularly applicable in thoracotomies where it is possible to maintain very light planes of anesthesia by using a 3.0 L. to 1.0 L. nitrous oxide-oxygen flow during the maintenance period and providing a potent analgesic effect with administration of piminodine. Very rarely, intermittent small doses of an ultra-short-acting barbiturate (50-75 mg.) were used to make the patient hypnotic, since the hypnotic effect of piminodine is minimal. The potency of this drug is indicated by the fact that though powerful painful stimuli were inflicted upon the patient as the result of the surgical procedure, in thoracotomy as well as other types of surgery,

Table 5

A. Effect of Piminodine on Blood Pressure in 232 Patients.

Initial	Lowest B.P.	Average B.P.	Final B.P.
128.41 ± 1.49 77.65 ± 1.05	105.13 ± 1.57 63.54 ± 1.02	123.36 ± 1.34 76.55 ± 0.97	$124.34 \pm 1.41 77.12 \pm 0.95$
B. Blood Pressure	Changes in a Control	Series of 180 Patients.	
Initial	Lowest B.P.	Average B.P.	Final B.P.
129.55 ± 1.73 77.43 ± 1.13	110.22 ± 1.65 68.49 ± 1.07	123.85 ± 1.52 76.36 ± 1.05	125.42 ± 1.76 77.43 ± 1.05
	128.41 ± 1.49 77.65 ± 1.05 B. Blood Pressure Initial	128.41 ± 1.49 105.13 ± 1.57 77.65 ± 1.05 63.54 ± 1.02 B. Blood Pressure Changes in a Control Initial Lowest B.P.	$128.41 \pm 1.49 \qquad 105.13 \pm 1.57 \qquad 123.36 \pm 1.34 \\ 77.65 \pm 1.05 \qquad 63.54 \pm 1.02 \qquad 76.55 \pm 0.97$ B. Blood Pressure Changes in a Control Series of 180 Patients. Initial Lowest B.P. Average B.P.

these were tolerated without marked changes in signs and depth of anesthesia.

Another situation of interest to the anesthesiologist is that of the reflex activity in the extremely light planes of anesthesia, manifested by bronchospasm, breath-holding, "bucking" on the endotracheal tube, cardiac arrythmias, and prolonged expiratory spasm. These phenomena are usually controlled by the total paralysis of the respiratory mechanism with the administration of succinylcholine or similar curare-like drugs. We feel that the administration of agents such as piminodine is equally effective and physiologically preferable in that they block the reflex stimulus.

Piminodine causes little or no circulatory depression. As can be seen from the blood pressures charted in this series, the average and final blood pressure readings are similar or only slightly decreased from the base or initial blood pressure readings (Table 5, compared with 180 controls).

Undoubtedly, changes in blood pressure occurred during anesthesia where piminodine was being used as they will with any other type of anesthesia. These changes, particularly hypotension, are invariably a manifestation of impaired circulatory function precipitated by innumerable causes, one of which may be the fluctuations in the anesthesia planes.

Once the data on blood pressure for this series of 232 patients were collected and tabulated, we selected at random an arbitrary number of cases (180) of surgery performed during about the same period of time to serve as a comparative group. The data on blood pressure of this group were similar, almost identical, to that of the 232 patients, indicating that blood pressure changes occurring in anes-

thesia under presumed influence of this drug are similar to the ones expected with the use of our other similar anesthetic technique. The blood pressure changes in the majority of cases were so mild in character as to be considered clinically irrelevant. Marked "blood pressure falls" were never found to be due to the direct influence of an adequate dose of this drug. However, the combination of a usual dose of piminodine and an over-indulgence in the administration of barbiturates or a potent volatile agent can precipitate a fall in the blood pressure.

Tachycardia and in some instances bizarre cardiac rhythms are a common occurrence under inadequate light anesthesia. Piminodine frequently restores the normal rate and rhythm. It has been utilized for this purpose in a number of cases in this series with reasonable success.

The introduction into the veins of the solution of piminodine mentioned in early paragraphs in this paper has in this series and subsequent number of cases been found to be devoid of any undesirable local phenomena. Likewise, we have not observed any idiosyncrasies which can be ascribed to this drug.

The facial itching, a very unpleasant common occurrence with the use of narcotics such as morphine, phenazocine, and meperidine, was never encountered with the use of piminodine.

A decrease, or at least no marked increase, of the salivary gland activity seems to occur with the use of this drug.

The emergence from anesthesia when piminodine supplemented nitrous oxide-oxygen technique is usually very rapid and smooth, characterized by lack of excitement and a marked return to cerebration. Secondary depression of

mental function is relatively infrequent and when it has occurred, has been invariably associated with an unusually "large" dose of barbiturates. Postoperative narcotic requirements are minimal for a long period of time, especially if small adequate amounts of sedatives have been used previously or are used in the recovery room. It should be mentioned that in a study of more than several thousand postoperative patients, we have found that if narcotics are not administered during the course of the surgical procedure, the usual time requirement for an analgesic is 3 hours and 50 minutes following emergence. With piminodine this time interval is prolonged in excess of two hours. We should emphasize that, if sedatives are used in patients when piminodine has been or is being employed, the amount of these should be kept at approximately one-third of that commonly used in the immediate postoperative period.

It is not in the scope of the present paper to present a discussion of the use of this analgesic agent in the postoperative period as this was not considered pertinent to this particular study; but work is being carried out on this phase, and we can so far state that it has been shown to be useful.

Conclusion

We feel that this study of piminodine covers too few cases to enable us to draw an absolute conclusion. However, it has impressed on us the fact that the drug is an effective, efficient, rapid, controllable, reversible narcotic analgesic having as its most undesirable aspect its "touchiness" when combined with respiratory depressant drugs. Its major advantage, and to a certain degree a disadvantage, is its freedom from higher cortical depression.

It is apparent from this study that when respiratory depression and over-all central nervous depression is undesirable, this agent may prove to be very useful; likewise, when analgesia is a primary requisite.

Summary

A series of 232 patients in whom a new narcotic analgesic drug, piminodine ethanesulfonate (Alvodine®), was used as a supplement to general and regional anesthesia is presented.

The method and clinical technique of administration is discussed. It was found that piminodine ethanesulfonate is a useful potent analgesic agent causing little circulatory depression and minimal respiratory depression when used alone but showing marked respiratory depressant action when used in conjunction with agents having marked depressant effect on the respiratory systems. Other actions of the drug are discussed.

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The alcoholic and his wife sought and found in each The Married Alcoholic other complementary, though often divergent, personalities, ignoring realistic signs of underlying personality disorders. In their fantasy they projected idealized images of each other to serve their own needs while these needs were actually incapable of being satisfied. After marriage reality forces awareness of his desperate alcoholism upon the wife. She may see that she may not be responsible for his alcoholism, but she may be one of the reasons for his continuing to go on sprees. William F. Gibbs, M.D. The Wife of the Alcoholic. Virginia M. Month. June 1961.

Indications for Emulsion (Repository) and Aqueous Therapy in Allergy

DONALD L. UNGER, M.D.*, and LEON UNGER, M.D.†, Chicago

EVER SINCE THE INTRODUCTION of injection therapy (hyposensitization) for hay fever by Noon in 1911,1 attempts have been made to decrease the frequency of injections. Finally through the work of Freund,2 Loveless,3 and Brown4 an oil emulsion for extracts now accomplishes this objective, but there has been much debate about the safety and efficiency of the resultant material. Some authors claim that emulsions are superior to and safer than aqueous injections, whereas others believe them to be unsafe. At this early stage in the evolution of emulsion treatment, we feel that neither extreme is correct; the old standard aqueous injections are by no means obsolete, and treatments with emulsified extracts are generally safe and effective. Each has its place in treating allergy; and until we have definite proof of the superiority of one or the other, we should individualize the type of treatment for each patient.

Indications for Emulsion Therapy

We believe that the following groups of patients should receive emulsified extracts:

1. Patients with one seasonal sensitivity. Such patients usually prefer one or two injections of

emulsified extract to 15 to 30 of the aqueous solutions. Most of them have taken no aqueous injections at all, finding them too much trouble for six weeks of discomfort; they struggled along with antihistamines instead. Many in this group are now taking emulsion treatment because of its simplicity (for them) and efficacy.

- 2. Patients not benefited by aqueous treatment. We have had patients who have come regularly for aqueous injections with no apparent decrease in their symptoms. On switching to emulsions, some have had amazingly good results. We can find no correlation between failure or success by one method and the results with the other.
- 3. Patients who have had repeated reactions from aqueous injections. Some patients have reaction after reaction from aqueous injections despite the utmost caution with dosages; they often stop treatment completely since the reactions may be worse than the underlying disease. Such patients may show the most spectacular benefits from emulsified extracts as they take few injections, rarely have reactions, and are able to tolerate comparatively huge doses of the offending antigen.
- 4. Patients unwilling to take aqueous injections. Many nonseasonal allergic patients prefer injections of emulsified extracts. The harassed mother wants her screaming child to get as few injections as possible. The busy executive chooses the method that gives him the greatest degree of protection in the least amount of time. The traveling salesman has trouble getting injections on a frequent schedule, and the farmer lives a long way from the physician's

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office. These people usually choose emulsion treatment and it seems tailor-made for their needs, despite the fact that they may need six or seven injections a year. They may be allergic to ragweed, grass, trees, dust and molds, for example, and need one or more injections of each.

5. Patients first seen just prior to a pollinating season. Whereas the ragweed-sensitive patient whom we first see in early July will get only slight benefit from aqueous injections, he will still get maximal protection with emulsions. We strongly urge that these patients be given this form of therapy. Neither method seems very effective during a pollinating season.

Indications for Aqueous Therapy

We believe that the following groups of patients should be treated with aqueous injections:

- 1. Patients successfully treated with aqueous injections in the past. We know that this patient gets good results with such injections and should urge him not to try the unknown.
- 2. Patients not benefited by emulsion treatment. Such a patient may well benefit from aqueous injections but may fail by both methods. Failures by both methods may involve psychological problems superimposed upon their allergies.
- 3. Patients who come for reasons besides injections. The majority of patients seen by the allergist come for more than injections. Injection therapy is not enough for the elderly man with emphysema or the chronic asthmatic on long-term steroid therapy. The injections may actually be an excuse to see the patient with the frequency required by his condition. To see such patients only once or twice a year would almost surely court disaster, and we strongly recommend that they be seen frequently; this is better accomplished with aqueous injections. Also, some dependent patients almost live for their biweekly visits to the physician, and it would be criminal to tell them that they need come only once a year.
- 4. Patients with furunculosis. They may well develop an abscess at the site of injection of emulsified extract, and such abscesses may cause a great deal of difficulty if improperly handled.

5. Negroes under six. Such children have been reported to have a high incidence of cyst formation after emulsion injections,⁵ although evidence for this is inconclusive.

Discussion

The above lists of indications are controversial and subject to additions and corrections. There is a large area of overlap. A busy executive with good results from aqueous treatment, for example, may demand injections of emulsions because of the time-saving element. Nevertheless, we believe that these lists can act as a general guide to choosing the type of treatment best suited for any given patient. Our major premise is that neither treatment is perfect, but both have their place in the management of allergic patients.

One final word of caution-no injection therapy will relieve the cat-sensitive patient who insists upon keeping his cat, or the man with baker's asthma who continues to bake. Avoidance of the offending antigens is still the best treatment.

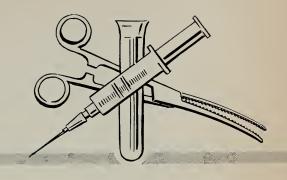
Summary

We believe that treatment with emulsified extracts is best suited for patients with a single seasonal sensitivity, those who were not benefited by aqueous injections or had repeated reactions from them, those unwilling to take aqueous treatment, and those first seen about a month prior to a pollinating season. Aqueous injections are preferred for patients who have had good results with them in the past, have not benefited by emulsion treatment, need frequent medical attention, have furunculosis or are Negroes under six years of age. These lists are tentative; we await further studies to help determine which type of treatment is preferable for any given patient.

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Anesthesia Conference



COOK COUNTY HOSPITAL

Belladonna Drugs: Importance in Spinal Anesthesia

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ALON P. WINNIE, M.D.,
VINCENT J. COLLINS, M.D., Chicago

THE BELLADONNA DRUGS are included almost universally as part of premedication for general anesthesia. The question often arises, however, as to whether these drugs should be included in the premedication of a patient who is to receive spinal anesthesia. The following case report illustrates the important role that the belladonna drugs play in spinal anesthesia, namely, in preventing the undesirable side effects of the anesthesia itself.

Case Report

This patient, a 58 year old gravida V, para III, colored female, entered Cook County Hospital with the chief complaints of urinary incontinence and burning. Physical examination found an obese female with a blood pressure of 140/80 mm. Hg, pulse of 80 per minute, and respiratory rate of 18 per minute. The entire

scheduled time of surgery. Nonetheless, the patient arrived in the operating room alert, coherent and cooperative. Blood pressure at this time was 120/80 mm. Hg and pulse was 60 per minute. She stated that she was not sleepy from her premedication, nor did she have a dry mouth. After 50 mg. of ephedrine was given prophylactically, lumbar puncture was performed between the fourth and fifth lumbar

vertebrae with the patient in the lateral posi-

tion; 80 mg. of mepivicaine in a 4 cc. hyper-

This article was developed from notes of a recent Cook County Hospital Anesthesia Conference a grade 2 cystocele and a retroverted fibroid uterus. The hematocrit was 41%, and the chest x-ray, electrocardiogram, blood chemistries, and urinalysis were all within normal limits. The patient was scheduled for vaginal hysterectomy and repair of cystocele and rectocele under spinal anesthesia.

Meperidine 50 mg., promethazine 50 mg.,

and atropine 0.5 mg. were ordered for premedication, but unfortunately these were ad-

ministered 1 hour and 30 minutes before the

physical examination was negative, except for

baric sloution was injected. The onset of anesthesia was rapid and complete, the final sensory level being at the thoracic segments 3-4. There was no decrease in blood pressure or tidal volume. The patient was placed in the lithotomy position, and surgery progressed uneventfully.

However, 35 minutes after the onset of anesthesia, the patient began to complain of severe bowel cramps, became nauseated, and even retched several times. She stated that she felt no pain from the surgery, but that the bowel cramps were unbearable. Atropine 0.25 mg. intravenously resulted in immediate relief from the cramps as well as an increase in pulse and blood pressure to normal levels. This dose of atropine was repeated 45 minutes later when the same symptoms reappeared, with similar response.

Discussion

Intestinal cramps, nausea and vomiting, and cardiac slowing are occasionally seen during spinal anesthesia. This is likely to occur particularly if the level of anesthesia and sympathetic block is high, and if anticholinergic agents were not given, or were given so early that they have worn off. Treatment with the belladonna drugs frequently prevents or relieves these symptoms, as was seen in the above case. Such phenomena have their basis in simple pharmacologic and physiologic fact, and it is to be emphasized that such knowledge is essential to the anesthesiologist in his everyday practice.

The effects of spinal anesthesia on the gastrointestinal tract are directly related to the extent of the subarachnoid preganglionic sympathetic blockade. The sympathetic nerves to the stomach serve to inhibit peristalsis and gastric secretion, to contract the pylorus, and to produce constriction of the gastric vessels. Spinal anesthesia high enough to cause sympathetic block up to the fifth thoracic segmental level would therefore be expected to be associated with increased peristalsis, increased secretion, and relaxation of the pylorus.1 Similarly, sympathetic denervation by spinal anesthesia produces contraction of the bowel due to the unopposed action of the parasympathetic nervous system, and thus is associated with an increase in the frequency of peristaltic waves.² The

changes in the gastrointestinal tract just discussed are not associated with any measurable alteration in splanchnic oxygen consumption, nor is there evidence that pooling of blood occurs in the splanchnic area.³

Abdominal cramping, nausea, and vomiting are most likely to occur in spinal anesthesia when the sensory level of anesthesia is higher than the tenth thoracic segment. At times, such disturbances are precipitated by vagal reflexes elicited by traction during intraabdominal manipulations, and at times they are caused by psychogenic factors. All three symptoms may occur, however, even before surgery has begun. In such cases the spinal anesthesia itself is clearly responsible through one of two possible mechanisms: cerebral hypoxia or increased gastrointestinal motility.

If arterial blood pressure falls to the extent that cerebral flow is decreased, central hypoxia will occur and may result in nausea and vemiting. This was obviously not the mechanism responsible in the patient presented above, for the blood pressure, though mildly depressed by the premedication, never decreased following the administration of the spinal anesthetic. In this patient the bowel cramps, nausea, and vomiting were most probably the result of increased gastrointestinal peristalsis secondary to the preganglionic sympathetic denervation of the stomach and bowel.⁴ This assumption is verified by the relief afforded by atropine.

In addition, as the level of spinal anesthesia approaches the fifth thoracic segment and extends above, there is progressive slowing of the heart rate. This is simply related to the block at the source of the preganglionic sympathetic fibers, which contribute to the cardio-accelerator nerves. Hence, the vagus again achieves progressive dominance. This physiological response must be appreciated during spinal anesthesia or errors in diagnosis of shock, hypotension, or reflex hemodynamic changes may occur. Again, the response to atropine is diagnostic of such vagal dominance, as we have shown in the case report, where the pulse and blood pressure were elevated to normal levels by this drug.

The belladonna alkaloids, atropine and scopolamine have two principal actions in the body. The first is on the central nervous system, while the second and more important is on the smooth muscle and secretory glands

innervated by postganglionic cholinergic nerves. All of the muscarinic effects of acetylcholine and its esters can be prevented by the belladonna drugs, and many of the responses to cholinergic nerve stimulation (or sympathetic denervation) can thus be blocked by atropine or scopolamine. The actions of all autonomic drugs, and especially the belladonna drugs, are conditioned by the level of activity of the gastrointestinal tract at the time of administration. In general, they decrease tone and peristalsis and enhance sphincter activity. However, these effects are much more pronounced when spasm and hypermotility are present, as in the case of the patient with high spinal anesthesia.

Although it has been stated that ordinary therapeutic doses of the belladonna alkaloids have no significant influence on normal peristalsis, endoscopic studies and fluoroscopy have indicated that atropine produces definite and prolonged effects on the motor activity of the duodenum, jejunum, ileum, and colon. These studies showed a marked decrease in tone and peristaltic movements after atropine, and a less striking effect on the rhythmic contractions.5

Summary

A case report is presented illustrating the occurence of bowel cramps, nausea, and vomiting in high spinal anesthesia without the occurrence of hypotension. These symptoms responded readily to intravenous atropine. The physiologic basis for the symptomatology and the pharmacologic basis for the response to atropine is presented. Such knowledge is essential to the practice of good anesthesiology.

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According to the ISMS Constitution . . .

CHAPTER XI. SECTION 10. Any component society which fails to pay its assessment or make the annual report required on or before April fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of April of the current year. Immediately after the first of April, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be automatically dropped. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition make application as a new member.

The View Box

FRANZ GAMPL, M.D., Chicago

The mother of the 2½ year old boy reported the child had been urinating frequently for 3 days and nights. She had noticed clouding of his urine and also had seen him pass a few clots of blood. Two months before the child had a bladder infection which cleared on symptomatic treatment. He lost 10 pounds over 3 months.

On physical examination he appeared poorly nourished and small for his age. His pulse was 108/minute, respiration 24/minute, and the blood pressure 158/110. A large, cystic-appearing mass was palpated in the left midabdomen. The bladder was felt two centimeters below the umbilicus. The urine contained 4+ albumen, and the sediment showed many red and white blood cells. Blood-urea-nitrogen was 36 mg. per 100 ml.

What is your diagnosis?

- 1. Wilms' tumor
- 2. Polycystic kidney
- 3. Bilateral hydronephrosis
- 4. Chronic glomerulonephritis (continued on page 275)

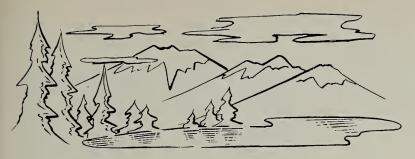


FIGURE 1. Intravenous pyelogram showing the film 70 minutes after injection of the dye.

From the radiology department, Cook County Hospital

False Research

Rigged medical research is as fraudulent as many ludicrous quack devices foisted upon a gullible public. When sanctioned and prepared by a physician and submitted in the form of a scientific paper to a medical editor, it becomes a betrayal of a trust, an abhorrent, vicious evil, and its perpetrator more dangerous to medicine than the quacks medicine is pledged to expose. Editorial. Rigged Research. New England J. Med. Nov. 30, 1961.



MEDICINE in the OUT-OF-DOORS

Gardeners' Dermatitis

Julius M. Kowalski, M.D., Princeton

INDIVIDUAL SUSCEPTABILITY and hereditary predisposition are important etiologic factors in hypersensitivities, as every physician knows. The degree of exposure or dosage (heavy or light) and the length of exposure (relatively long, short or intermittent) will influence the clinical findings in a given case. Though this is an overstatement, one might consider that eventually a substance can be found, be it an inhalant, ingestant or contactant, to which the most insensitive person will react. The last word on antigen-antibody reactions is yet to be written. The interaction of these and other variables is often incomprehensible to the average patient; and further, since response to treatment can be slow even in this age of medical miracles, he becomes discouraged. Apprehension, restless sleep, itchy or painful skin, feverishness, and other inequilibria accentuate his disconsolation. It is good medicine to forewarn the ebullient one who is about to zealously embrace the great outdoors that danger and discomfort lurk everywhere for the unwary in this domain.

There is an irrepressible urge to get outdoors after a long, cold winter to putter about in the yard after reading glowing descriptions about innumerable plants in the new seed catalogs. The gathering and burning of leaves, plants, and yard debris left over from the previous fall can spell the beginning of trouble for the enthusiastic gardener. Dust and smoke from such operations act as mechanical irritants to the nostrils and upper respiratory tree. Since the ubiquitous poison ivy twigs and leaves are diffi-

cult to identify amongst the spring yard refuse, smoke from such burnings will affect the skin in the same manner as direct contact. Obviously, one should avoid all smoke and dust whenever possible. Where exposure to such conditions will be prolonged, it is advisable to wear a respiratory mask.

With the coming of warmer weather, planting and transplanting is pursued in earnest. It's so satisfying to be the first in the neighborhood with blossoms, trimmed hedge, and edged lawn—the only status symbol for some. To achieve this end, plants, shrubs, and trees are handled at times with abandon, and their continuous or repeated contact with predisposed skin results in contact dermatitis—dermatitis venenata.

This acute inflammation of the skin can be caused by contact with any type of substance—plant, animal, or chemical. Erythema, swelling, itching, and burning on surfaces exposed to the irritant are the first symptoms. Vesicles often develop in the primary site, and involution follows in one to three weeks with crusting and scaling. These findings may be observed on areas distant from the site of initial contact and are spread by scratching, perspiration, or by contaminated clothing. Pustules and infection are frequent complications in traumatized cases

Plants that regularly are serious offenders belong to the poison ivy group, which includes poison oak and poison sumac. Every effort should be made to avoid these at all times. The poison ivy group affects millions each year.

The only sure way to be spared this discomfort is to shun these plants which often grow as vines, shrubs, and/or small trees. "Leaves of three" on a single stem is the hallmark of poison ivy and poison oak. The morphology of this group is extremely variable, and for that reason identification is difficult if one is to rely solely on reading about them. Field trips with a competent guide or visits to museums supplemented by drawings and photographs are best for developing assurance in identification. In just this manner, youngsters in many youth groups across the land learn each year; their parents should do likewise.

The primrose family, species of which are found in almost every flower garden, is responsible for many cases of contact dermatitis, particularly *Primula obconica*. But it would be unfair to single out the primroses since any one particular plant can be noxious to a given individual. This is a highly specific reaction. Thousands of individuals make many hundreds of thousands of contacts with the primroses each year, and a number of persons will become unhappy for this intimacy. The same can be said for the pink lady's slipper, a wild-growing orchid of the north woods.

The mushrooming of suburbia and the landscaping which accompanies it has resulted in importation of many exotic plants or those which under normal conditions would be rarely handled. Evergreens, reminiscent of the pure, cool north country, appear on many Midwestern lawns. This was their habitat 5 to 10 thousand years ago, but with the glacier regressions it moved northward. As a result, now many persons demonstrate dermatitis venenata reactions from evergreens that grow about their homes. In this group of occasional offenders are the spruces, cedars, pines, junipers, and other evergreens.

Besides the exotic and new imports, the old stand-by plants such as tomato, chrysanthemum, and geranium affect sensitive skins.

The group of plants most likely to traumatize the skin — saw grasses, thistles, smartweeds, and stinging nettles — are mentioned in that they are frequent invaders of domestic gardens. The picnicker, camper, or fisherman is most likely to run afoul of this group in its native habitat.

The application of fertilizers, insecticides, and weed killers is very serious business. Only after reading all the directions on the containers and knowing the antidotes to be used in the event of poisoning, and being sure that these aids are available in the home, should the containers be opened. When directions state that children and pets must be kept away from areas of application, just that is meant. These lethal products must be properly stoppered and out of reach of children at all times.

Illinois is fortunate in having strategically located poison control centers throughout the state, and physicians and hospital personnel have telephonic information available at a moment's notice at all hours from these centers. Other states have comparable programs.

Exercising mature judgment and having a sincere respect for the newer gardening prodducts will alleviate needless suffering. All skin surfaces should be covered and clothing changed if the job is a prolonged one. Plant juices and gardening applicants should be washed from the skin frequently. Wearing a respiratory mask is desirable whenever using dusts or sprays. The eye-appealing lady in bikini and shorts with youngsters romping about her on the lawn as she tends the yard makes for a good advertisement — but not for family safety.

A Million's Worth

"All American industry has contributed, but I must give a special vote of thanks to the pharmaceutical industry, which has contributed in excess of \$1 million in cash and drugs to our effort. I have no idea how many other foundations like our own are able to carry on their work because of this great industry, but because this industry has a heart, this award belongs as much to them as it does to me."

— William B. Walsh, M.D., founder of Project HOPE, on receiving 4th Annual Health U.S.A. Award.

The $View\ Box$ —diagnosis and discussion (continued from page 272)



FIGURE 2. Voiding cystourethrogram

The diagnosis is bilateral hydronephrosis (bladder neck type obstruction).

Radiographic findings: The voiding cystourethrogram showed a hypertrophic, trabeculated bladder. The internal sphincter at the bladder neck also showed hypertrophy. The posterior urethra is considerably dilated up to the level of the colliculus seminalis (verumontanum). At this point there is a radiolucent membrane of the shape of an inverted "V", which is the pathognomonic appearance of an urethral valve.

Discussion

The symptoms in children with congenital bladder neck obstruction are often those of an acute urinary infection of recent onset. Information given by the parents is usually scant. Although the urinary obstruction exists since birth, mild, recurrent urinary infections and dribbling on urination often go unnoticed for long periods. Enuresis continuing beyond the usual age may be the first symptom noticed by the parents. For early detection of malformations in the lower urinary tract of children it is of extreme importance to observe the urinary stream. A forceful and continuous stream in a high trajectory is a sign of a well functioning lower urinary tract.¹

The etiology of bladder neck type obstruction in childhood is varied. Hypertrophy of the internal sphincter at the bladder neck, congenital valves, phimosis, and other malformations of the penis and urethra are common causes. Tumors compressing the urinary pathways, neurogenic bladder, and deficiency of the musculature of the anterior abdominal wall are less frequently found. Bilateral hydrone-phrosis and delayed excretion of dye on intravenous pyelography do not indicate a hopeless prognosis. Corrective procedures will revert the changes if the diagnosis is made at an early age.

If intravenous pyelography and cystoscopy fail to demonstrate the site of the obstruction, voiding cystourethrography, either by plain radiography or cineradiography, is often successful in demonstrating the lesion.

Complications: Uncorrected malformations which interfere with the normal micturition will lead to retardation in development, anemia, and all the severe metabolic disturbances of uremia.

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Watch for April issue – Illinois Medical Journal

for HANDBOOK of the 1962 ANNUAL MEETING

Delegates Will Not Receive Handbook Prior to Registration

Acute Porphyria: A Case with Multiple Perforations of the Terminal Ileum and a Coincidental Carcinoma

MAX BERG, M.D., Ph.D., Chicago

Paroxysms of Abdominal Pain, nausea, vomiting, and distention are frequent manifestations of acute intermittent porphyria. Various acute abdominal conditions have been simulated by these attacks, such as bowel obstruction, acute appendicitis, cholecystitis, pancreatitis, and torsion of an ovarian cyst. Patients have been operated on, perhaps several times, before the correct diagnosis was established by adequate examination of urine. Conservative measures may appear to be in order, but surgery may be required for mechanical disturbances of the bowel secondary to porphyria—such as volvulus of the cecum, or obstruction or a complicating carcinoma of the colon.

Case Report

A 38 year old housewife admitted to Englewood Hospital July 25, 1958, complained of severe colicky abdominal pain and distension, and of vomiting fecal material for several days. She had been relatively free of symptoms since her discharge from the hospital for a similar episode one month previously. In March, 1955, she began to complain of intermittent lower abdominal pain, frequently centering around the umbilicus and associated with occasional nausea. The attacks increased in frequency and severity, and she was hospitalized in March, 1956. X-rays of the gastrointestinal tract and

gallbladder, an intravenous pyelogram, the blood count, and urine were essentially normal. The patient was discharged "undiagnosed."

When hospitalized again on April 14, 1958, for sudden, severe colicky abdominal pain and vomiting of 12 hours' duration, she developed lower abdominal tenderness and a questionably palpable mass in the left lower quadrant. She had moderate leukocytosis and hypochromic anemia. A tentative diagnosis of a ruptured grafian follicle was made, and an exploratory laparotomy performed. No abnormalities were found.

Six weeks later she was readmitted because of recurring attacks of severe colicky abdominal pain associated with nausea and copious vomiting, frequently of feculent material. During the attacks she noted increasing abdominal distention and a mass in the right lower quadrant which disappeared suddenly after the acute attack and recurred with each succeeding attack. She had lost weight and was pale and dehydrated. The abdomen was distended, tympanitic, and slightly tender over the lower portions. A sausage-shaped hard mass was palpated intermittently in the right lower quadrant. The pulse rate was 80 per minute, and the blood pressure 110/60. The initial leukocyte count was 11,200 cells per cu. mm. with 84 per cent neutrophils, 13 per cent lymphocytes, and 3 per cent monocytes. The hematocrit was 47 per cent and hemoglobin of 16.4 Gm. per 100 ml. The serum amylase was 8 units per 100 ml., the nonprotein nitrogen 47 mg. per 100 ml.; total serum protein 5.8 Gm. per 100 ml. with the serum albumin 3.27 and globulin 2.1 Gm. per

From the department of medicine, Englewood Hospital; Cook County Hospital; the department of medicine, University of Illinois College of Medicine

100 ml. Blood chlorides, sodium, and potassium were normal.

The cephalin flocculation, thymol turbidity, bromsulfalein retention, and icterus index were normal. Stool examinations revealed a 1-plus positive reaction for occult blood and were negative for ova and parasites.

After the acute symptoms subsided, serial films were made at half-hour intervals for five hours and supplemented by films at 6, 7, and 24 hrs. (Fig. 1, p. 278). There was normal transit of the contrast material through the proximal and apparent mid-portion of the jejunum, but a slight delay in passage through the distal jejunum and hypermotility through the ileum. The mucosal pattern of the ileum appeared abnormal with areas of increased and decreased caliber which were not constant, and with multiple areas of segmentation of the barium. At the end of the five-hour examination the barium had reached the midtransverse colon.

Some 12 hours after the onset of the examination, another attack of vomiting and colicky abdominal pain developed. At the 24 hour examination, while a small amount of the contrast material was present in the distal colon, the larger amount was observed throughout the proximal colon, ileum, jejunum, and duodenum. The previously demonstrated segmentation of the contrast material in the ileum was lacking, but the increased caliber and accentuation of the mucosal pattern were still present. A tentative diagnosis of atypical ileitis was entertained; corticosteroid therapy gave symptomatic improvement.

On her final admission July 25, 1958, she was emaciated, and had an acneiform eruption on her face. The pulse rate was 120 per minute and the blood pressure 130/102. The lungs were clear. Examination of the heart revealed only a tachycardia. The abdomen was distended and slightly tender with diminished bowel sounds. A small mass was palpated intermittently in the right lower quadrant. The urine, Burgundy red, darkened on exposure to light, and on exposure to ultraviolet light gave a red fluorescence. The Watson-Schwartz test for porphobilinogen was strongly positive. She received intensive fluid and electrolyte therapy with restoration of normal values. The laboratory data are summarized in table 1. Addi-

TABLE 1. SUMMARY OF LABORATORY DATA OF THE PATIENT'S LAST ADMISSION TO HOSPITAL

PATIENTS.					
DATE	7/24	7/25	7/26	7/28	7/30
Hemoglobin	10.7	17.4	14.9		12
Hematocrit	33	50	44		36
Leukocytes	16,250	8,200	10,800		
Polymorphonuclea	rs 79	85	25		
"Stab" forms	10	5	40		-
Lymphocytes	9	6	28		
Monocytes	2	4	7		
Chlorides	52.5	98			
Sodium		141			
Potassium		5.4			
Nonprotein					
Nitrogen		57		46	
Creatinine			3.1		
Total Protein			6.9		
Albumin			4.9		_
Globulin			2.0		
Alkaline					
Phosphatase			22.6	13.1	
Inorganic					
Phosphorous			4.3		
Urea Nitrogen		33		27	
Thymol Turbidity			2		
Cephalin					
Flocculation			3+		
Serum Bilirubin				1.5	
Uric Acid		3.6			
Cholesterol				220	
Cholesterol Esters				72%	
Bromsulfalein					
Retention				—	4%

tional therapy included a continuation of ACTH, prednisone, and Calcium Disodium Versenate® (calcium disodium ethylenediamine tetra-äcetate). Symptoms subsided, and by the third day oral feeding was resumed. The tachycardia abated, and the blood pressure returned to normal. The patient had normal-appearing stools positive for occult blood. Nitrogen retention diminished; excretion of porphyrins and porphobilinogen subsided.

While continuing to improve, receiving only a maintenance dose of prednisone, she suddenly began to vomit, became distended, and went into profound shock. The tests for porphyrins and porphobilinogen in the urine again became positive. She rapidly developed oliguria and coma, and she died on Aug. 4.

Post-mortem examination revealed diffuse purulent peritonitis and multiple perforations





FIGURE 1. Serial roentgenograms of small bowel by fractional technique showing (A) 2-hour view of normal jejunal and abnormal ileal pattern and segmentation; (B) 5-hour film with altered areas of ileal segmentation; (C) 7-hour film

with barium in the ascending colon, spasm segmentation, and abnormal ileal pattern; (D) 24-hour film taken hours after onset of fecal vomiting showing barium distributed in the ileum, jejunum, duodenum, and stomach.





of the ileum 15 cm. proximal to the ileocecal valve. Several pinpoint mucosal erosions were found in the stomach, terminal ileum, and colon. After the ileum was removed and multiple sections were made, a tumor about 1 cm. in diameter was noted some distance from the perforations. Atelectasis of the lower lobes of both lungs was present.

On microscopic examination marked inflammatory reaction involved the serosa of the intestines. In the mucosal and muscular layers the architecture was normal except for some lymphocytic infiltration. Sections of the ileum showed the ulcerated necrotic area extending down to the submucosa where there were dilated vessels and a few lymphocytes and fibroblasts (Fig. 2). In other areas the connective tissue appeared swollen. In the myenteric plexus the nerve cells were swollen with moderate chromatolysis (Fig. 3). The adenocarcinoma of the ileum is shown in figure 4. Pronounced changes were observed in sections through the cervical spinal cord. The anterior horn cells were decreased in number with frequent indistinct nuclei and marked chromatolysis of most of the identifiable nerve cells. In sections through the pons nonspecific alterations, chromatolysis, and gliosis were present. The small vessels of the meninges were dilated and engorged with blood. Myelin sheath stains revealed no loss of myelin. Many of the hepatic cells contained large cytoplasmic vacuoles.

Acute porphyria is uncommon, having been reported in 0.04 per cent of cases admitted on the medical service of a university hospital in recent years.1 A review of the cases of porphyria admitted to Cook County Hospital in Chicago for the decade 1948-1958, revealed no cases for the first five years and 6 cases in the latter five years. Multiple perforations of the ileum associated with acute porphyria appear to be rare. No reports in the literature of a similar case have come to our attention, and none were found in reviewing the cases at the Cook County Hospital. A case of volvulus of the cecum secondary to porphyria with gangrene of the cecum and a portion of the ileum and ascending colon, and another case of gangrene of a portion of the ileum showed that mechanical factors may occur secondary to porphyria involving the ileum.

The severity of the attacks characterized by

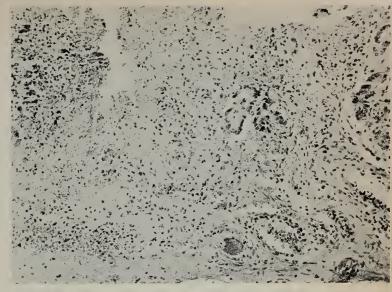


FIGURE 2. Photomicrograph of ulceration of ileum showing transition of the marginal epithelium to necrotic cells, fibrin, leukocytes, fibroblasts, and dilated vessels.

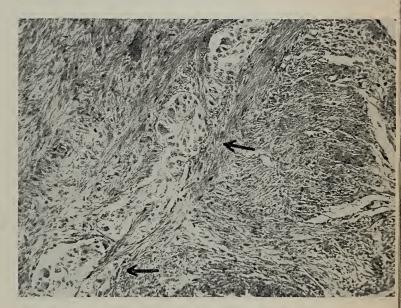


FIGURE 3. Photomicrograph of ileum showing swelling and chromatolysis of nerve cells of myenteric plexus.

FIGURE 4. Photomicrograph of the adenocarcinoma of the ileum.



feculent vomiting, the intermittent abdominal mass, and the unusual roentgen findings during the acute coisode are noteworthy. These are consistent with a disturbed motor function, characterized by reverse peristaltic movements of most of the intestinal tract. There was also an alteration of the ileal pattern different from the abnormal pattern observed during the quiescent phase. In addition, there were localized areas of spasm and dilatation, as reported in the literature.^{2,3,4} These motor disturbances appear to reflect the functional and the anatomic alterations of the autonomic nervous system previously described, 2,5,6 as well as the swelling and chromatolysis of the nerve cells of the myenteric plexus noted in the ileum.

There has been a tendency to think that the accumulation of abnormal intermediate metabolites of porphyrin metabolism might be the mechanism involved acting directly on the enzyme systems of the cells. It has been suggested that the spasm of smooth muscles produced by porphyrin, particularly of the small blood vessels, might produce an ischemia⁷ and thus damage the nerve cells.

In considering the pathogenesis of the multiple perforations of the terminal ileum, the abnormal motor function of the bowel during the acute attack may predispose to ulceration. Spasm of the smooth muscle and the small arterioles may be a contributing factor. A possible effect of the glucocorticoids in producing ulcerations and perforations in the jejunum and ileum^{8,9,10} may be significant. Delayed healing caused by the corticosteroids is reported to be augmented by a pre-existing protein depletion, 11 and this may have occurred in the debilitated state of our patient.

Favorable reports have appeared on the treatment of acute porphyria with chelating agents.12,13 The mechanism of action of the agent ethylenediaminetetraacetic acid (EDTA) is not known; it might be due to the removal of excessive amounts of certain metal complexes such as zinc, iron, or manganese producing an enzymatic block; or to a nonspecific effect. Increased levels of zinc excretion in the urinc have been observed in acute porphyria, 12,13,14 as well as in patients with hepatic dysfunction.¹⁵ Administration of EDTA has also been associated with a definite worsening of the clinical course of acute porphyria. 16 In this

case the administration of EDTA was not associated with any untoward reaction, and the clinical improvement may have been the result of the natural course of the disease.

Malignant tumors of the ileum are comparatively rare, and the reported cases of carcinoma associated with porphyria are relatively few. The association of a carcinoma of the descending colon with acute porphyria has been reported.¹⁷ In a review of 81 cases of porphyria, 18 one case of carcinoma of the stomach with metastases was noted, while in other reviews,^{2,14} no cases were cited.

Summary

A case of acute intermittent porphyria (porphyria hepatica) of at least three years' duration was associated with multiple perforations of the terminal ileum and a small carcinoma of the ileum. The factors in the pathogenesis are considered and the bizarre clinical picture is correlated with the abnormal roentgen findings and with the autopsy report.

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Adenocarcinoma of the Vermiform Appendix

LEO BRAUNSTEIN, M.D., Chicago

CARCINOMA OF THE VERMIFORM appendix was first mentioned in medical literature in 1902, when one case was reported. Since then approximately 84 others have been recorded, most of which are authentic. In the first decade of this century, staining technics were improved and this factor contributed to a more accurate appraisal of histologic diagnosis. Previously no serious attempt was made to differentiate primary carcinoma from carcinoid and mucinous carcinoma, but Niceberg¹ et al. in 1954 proposed to classify carcinoma of the appendix in three groups based on histologic features, and accordingly put carcinoid in Group 1, mucocele in Group 2, and adenocarcinoma in Group 3 - commonly referred to as the colonic variety. This simple classification is reasonable, accurate, and acceptable and is generally employed by most writers. In 1956 Sieracki and Tesluk² expanded the grouping of adenocarcinoma of the appendix on a regional basis, but their listing leaves loopholes for errors of interpretation and does not contribute to pathologic interest.

One need only review the literature to appreciate how rare this lesion is. The first case report appeared in the European literature. During the next 60 years a total of about 84 cases has been presented. Young and Wyman³ reviewed 4 cases and added a fifth. Uihlein and McDonald⁴ in 1943 collected 5 cases at the Mayo Clinic over a 31 year period. Hilsabeck⁵ reported 12 cases at the Mayo Clinic over a 39 year period in 1949. Nine of these were authentic microscopically, and 3 were polyps with malignant changes at the base. We would probably call these carcinoma in situ. Also in 1949 Lesnick and Miller⁶ commented on 12 authentic cases and added 5 of their own. Lawton and Ehrlich⁷ in 1952 reviewed 22 cases and presented 5 more in their series. Clarke and Simonds8 in February, 1953, reported on 33 and

in October, 1953, LeBrun⁹ could find only 26 cases. The total of all reports, 10-17 to date is estimated at 84.

Of all primary carcinomas of the appendix, adenocarcinoma comprises about 3 per cent. The age distribution is similar to malignant neoplasms in other organs, the most common group being 47 to 70, which applied to 72 per cent of those here reported. Incidence in males was twice that in females; no explanation is offered for this observation. It is notable that a preoperative diagnosis has not yet been made. Signs of appendicitis or bowel obstruction have been the most characteristic and frequent indications for surgical intervention. In the case here presented a tentative diagnosis might have been made, inasmuch as the referring physician had felt a tender mass in the appendiceal area on two previous episodes. At the time the patient was seen by the writer, a typical case of acute appendicitis was apparent.

Treatment

Some comments relative to treatment are pertinent. When one encounters an inflammatory mass involving the appendix, appendectomy should suffice, since several benign surgical entities may account for the pathologic process which would not require a more radical procedure. Consensus favors this course of treatment. After the permanent sections reveal the presence of carcinoma, a radical bowel resection in the right half is indicated as soon as the diagnosis is confirmed. A study of the statistics showed that 91.7 per cent of patients survived three years or more after right hernicolectomy, whereas 73.1 per cent survived three years after appendectomy alone.

The following case was encountered by the writer recently, and is presented as the 85th recorded case of primary adenocarcinoma (colonic variety) of the vermiform appendix.

Case Report

D. K., married female, age 37, was hospitalized August 10, 1961, for sudden onset of severe, abdominal cramps, pain in the right lower quadrant, vomiting, and fever of 6 hours' duration. She had two similar episodes but without fever in the past six months, with complete recovery after a few hours and no specific treatment. There was no previous abdominal surgery nor major medical ailment. Her last menstrual period was normal. Physical examination showed a very acutely ill white female, unable to lie quietly because of generalized abdominal cramps and extreme tenderness over the cecal area, muscle spasm, and resistance to deep palpation. Rebound tenderness was present with hyperesthesia. Pelvic examination confirmed the tenderness on the right side, but no mass was palpable. Her oral temperature was 103 F., pulse 100 and respiration 14 per minute, and blood pressure 120/80. The hematocrit was 36%, hemoglobin 12.6 Gr./100 ml.; leukocytes numbered 10,000, neutrophils 84, lymphocytes 16 per cu. mm. Urine was within normal limits. A diagnosis of acute appendicitis was made and surgery arranged.

Surgery

Under pentothal and cyclopropane anesthesia, the abdominal cavity was entered through a low midline incision. There was an inflammatory mass in the right lower abdominal quadrant, involving the omentum, right tube, ovary and suspensory ligament, terminal ileum, appendix, and cecum. In the center of this diffuse mass was a more delineated, firm mass apparently in the appendix. A line of cleavage was established by sharp and blunt dissection freeing the omentum, right adnexae, and cecum. The appendix was then mobilized without encountering any malignant tissue on its surface or adjacent organs or tissues, and removed. It contained an isolated, firm, slightly nodular encapsulated mass, which at no point appeared to have penetrated the serosa. A retrograde appendectomy was done. The abdominal cavity was closed in layers without drainage and the patient transfered to the recovery room.

The immediate postoperative period was not

remarkable. On the fourth day after surgery the pathology report was received indicating adenocarcinoma of the appendix. The patient was again taken to the operating room for right hernicolectomy as a definitive procedure. The terminal ileum, cecum, and ascending colon were excised and bowel continuity restored with an end-to-end ileocolostomy. There was no gross indication of residual carcinoma.

The second postoperative course was smooth, with the patient out of bed on the second day and home on the tenth. Since then there have been no complaints and no further treatment.

Pathology Reports

First Specimen, August 11, 1961. Gross: The specimen consists of an appendix measuring 7 cm. in length and up to 2 cm. in diameter in the area of the proximal resected edge and up to 3 cm. in diameter in the area of the tip. The covering serosa has a dull and somewhat lusterless appearance, and in the area of the tip it is partially covered by yellowish-green purulent exudate. The attached portion of omentum-like tissue measures up to 5 cm. in width. On cut section the proximal portion of the appendix reveals a markedly thickened wall that measures up to 5 mm. in thickness and a virtual obliteration of the lumen that is markedly compressed and forms a crescent-like slit. The compression of the lumen is seemingly due to a homogeneous tannish-yellow mass that appears to arise from he submucosa and bulges into the lumen. The muscularis in some areas shows the presence of small abscess-like cavities filled by grayish-yellow purulent material.

Microscopic: The tumor consists of glandular structures of varying size and shape lined by atypical columnar epithelial cells. These cells have amphophilic cytoplasm and large, hyper-chromatic, irregular nuclei with pleomorphism, polychromasia, and moderate mitotic activity. Some of the glands are filled with mucin. The tumor in some places extends to near the sero-sal surface.

Microscopic Diagnosis: Adenocarcinoma of appendix. Marked chronic and acute appendicitis.

Second Specimen, August 16, 1961. Gross: The specimen consists of the terminal portion of the ileum measuring 28 x 1.5 cm. and the cecum

with a portion of the ascending colon measuring 12 x 4.5 cm. The serosal surface is bluishgray-pink, smooth and shiny, with the exception of an area on the posterior surface of the cecum and of the lateral surface of the portion of the ileum just above the ileocecal junction. The edges of these incisions are united by black surgical silk, and they measure 4 and 3 cm. in length respectively. The attached mesocolon measures up to 4 cm. in width, and the mesentery measures up to 2 cm. in width. In the mesocolon several large lymph nodes are palpated which on cut section show gravish-white, edematous, lymphoid tissue of seemingly normal architecture. In the opened specimen the mucosal surface of the ileum and the large intestine appear to be normal, and the stump of the removed appendix is identified. A few shallow diverticula of the cecum are present. Representative sections were taken.

Microscopic: There is no evidence of tumor in the stump of appendix, terminal ileum, cecum, and regional lymph nodes.

Comment

This patient presented clinical, physical, and laboratory findings consistent with acute appendicitis. The presence of carcinoma was probably the factor that precipitated the acute process. The sequence of events is similar to those cases studied in the literature. Nothing

less than right hernicolectomy is acceptable after the diagnosis of carcinoma is established.

Summary

Adenocarcinoma of the appendix is rare. Eighty-four cases have appeared in medical records to date. Another case is presented herewith.

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Editorials

Education, Science, and Democracy

According to Nicholas DeWitt, "Soviet leaders firmly believe that the competition between capitalistic democracies and the communistic world will be decided in the field of science and technology." This is the rationale for their own emphasis on engineering and sciences in their professional training program. This aspect of their program must not be misunderstood or underestimated. The Russians could do considerable damage to this country if they concentrated on 30 H-bombs capable of hitting the bull's-eye in 30 of our largest metropolitan centers. Why should they concentrate on developing lifesaving drugs and laborsaving devices; they will reap the benefits of these too, if — those 30 bombs hit the target.

The comments relative to the bombs are ours; those of DeWitt appeared in *Science* and represent a superb new study of Soviet education. Their higher educational institutions are professionally oriented; they do not have general education or liberal arts colleges nor non-professional-oriented undergraduate programs of instruction.

"DeWitt points out that the Soviet concept of 'specialization' is a particularly narrow one. It entails,' he explains, 'training in an individual, narrowly defined field of professional knowledge, which will equip the student to perform a given occupational job.' For purposes of accomplishing that job, DeWitt argues, the system has unquestionably produced impressive results; but the Soviet Union's recruitment of administrative leaders from this pool of narrowly trained specialists poses serious questions

about the kind of leadership that is being developed in the Soviet Union.

'Soviet specialists,' DeWitt says, 'are employed not only in the occupations for which they were trained, but to a degree unknown in the West, in managerial and administrative positions in the economic, social, and even political affairs of the state.'"

In this country 60 per cent of the 87th Congress are lawyers, and less than three per cent are physicians or engineers. According to De-Witt, 40 to 50 per cent of the delegates to the recent Party Congress are engineers and scientists. The implications are somewhat disturbing because it means that the Soviet specialist "with his lack of humanistic education and disregard for the cultural, ethical, and social values cherished by the West [is limited] in participating in the solution of the important social and political problems which divide the Soviet Union and the democratic world today."

There is a good possibility that this is a deliberate attempt by the Russians to keep their engineers and scientists as tools in serving the aims of the communistic regime. According to *Science*, the plan develops a highly competent mind in many areas but deprives it of its potential to exercise creative and independent thought. DeWitt estimates that at least one third of the Soviet specialists now are engaged in administrative tasks that are performed in in the United States by liberal arts and business graduates.

But this is only a part of the story. The undergraduate student who does not become a candidate for higher education must spend some time in productive labor. During the past decade, reforms have shortened the period of "full time general schooling and emphasized vocational training and on-the-job training." As a result, the more intelligent youth are given the opportunity to continue, but the remainder and majority are dropped from school at an earlier age to help swell the labor force.

It has been said that the rich get richer and the poor get poorer. In Russia the smarter get richer and the dumb get poorer. In this country we also hear that the specialists know more and more about less and less. Perhaps these adages will in time prove to be the downfall of the Soviet Union.

Saving by Spending

Like all of Mr. Kennedy's proposals, his new plans for public welfare hold out the prospect of saving money in the long run by spending more now. Immediate added costs on this latest scheme: 193 million dollars. That much would be certain; the "savings" would be hypothetical. It is predictable that they would never materialize.

In 1937, when there was a depression, federal public assistance was limited to 140 million dollars, with state and local governments paying not quite five times as much. Now, in times which the Kennedy administration characterizes as prosperous, the load on the federal taxpayers has risen to more than 2 billion dollars a year, with state and local taxpayers bearing about the same burden. Thus, in a generation, the cost has gone up almost six times, even tho part of the 1937 costs have shunted to social security.

It is impossible to account for this huge increase in costs on any other basis than that eligibility standards have been relaxed, injudicious "cost of living" increases have made the free ride even more attractive, family responsibility has been slighted, and the sphere of private charity substantially preempted.

Yet Mr. Kennedy had only harsh words for those who, like the officials at Newburgh, N. Y., try to tighten relief standards and promote selfhelp. He referred to the measure attempted there as "ruthless and arbitrary" and unsuccessful. He did not say that because of the federal clout over the state thru "matching fund" provisions, and the state clout over the local community, the effort to get free loaders off the rolls never had a chance.

There is a genuine need among unfortunate elements of the population, but Mr. Kennedy's ideas are not going to repel the undeserving — not when he raises certain of the stipends and offers incentives to the states to eliminate or shorten residency requirements.

The message speaks of "prevention and rehabilitation" rather than "salvage," but it is to be doubted that much will come of his proposals for retraining dependent persons and schooling fresh battalions of social workers. What, for instance, does all this offer Illinois — a state whose governor admits it is going broke largely because of the public aid problem? The answer, we fear, is some Kennedy verbiage and some added costs.

Editorial reprinted with permission from the Chicago Tribune, Feb. 7, 1962.

Testing New Drugs

During the past year several warning letters have been circulated relative to the untoward side effects of several "new" drugs. The list includes zoxazolamine (Flexin) because of possible hepatotoxicity, furaltadone (Altafur), and two antibiotics — erythromycin propionate lauryl sulfate (Ilosone) and triacetyloleandomycin (Tao, Cyclamycin, and Tain). New information relative to TAO and Cyclamycin have been received during the past month. Suggestions were made relative to dosage schedule that allow safer administration.

The transquilizer amphenidine (Dornwal) was withdrawn because of reports of agranulo-cytosis. Warning notes relative to dithiazanine (Delvex) were also noted. This valuable anthelmintic was strongly suspected as causing six deaths and should be used only with suitable caution.

Triparanol (MER/29) is the latest. This drug has been promoted for use in hypercholesterolemia and coronary artery disease and has been shown to cause cataracts, baldness, loss of body hair, and changes in hair color and texture. Reports of skin changes ranging from dryness to severe exfoliation have appeared along with possible depression of the adrenal cortex and impotence.

This wholesale warning demonstrates that many drugs are brought into general use prematurely. The effectiveness of any product can be determined only by properly planned, controlled, therapeutic trials. During this period the frequency and severity of side effects are noted, but it is obvious that several years must elapse before the more lethal aspects of the story are established. The pharmaceutical industry has become so competitive and drugs become obsolete so quickly that many firms are forced to market their product as soon as possible. The suggestion by Senator K that drug patent rights be reduced to three and a half years will serve only to accentuate this need for embarking on an extensive advertising campaign to sell the product before the hazards are fully recognized.

The time may come when the proper assessment of a new drug will require more reliable clinical appraisal. This responsibility could be shifted back to the American Medical Association or to other medical bodies. The majority of manufacturers might prefer an unbiased opinion or at least to be freed of the responsibility for the claims made for new products. Meanwhile, physicians must be more critical of reports on new remedies and learn to evaluate the results of treatment in the light of controlled therapeutic trials. Let us not forget the adage, "Be not the first to try the new nor the last to use the old."

Progress and Hunger

Is progress good or bad? India's population is over twice as large as ours, but her land area is scarcely more than one third as large. In addition, it is 80 per cent rural. Her annual birth rate is unchanged, but during the past decade the death rate has fallen considerably due to improvements in public health and the spread of preventive medicine. As a result, India's population has increased 40 million in the past five years. This represents an annual increase of nine million in contrast to three million for the U.S.A. India is second in size to China with a population of 440 million. The U.S.S.R. is third, and the U.S.A. is fourth with 183 million.

This type of information carries a connotation that now is well established in Washington.

The increase in population creates the danger that hunger will be even more widespread in India within a few years. Since freedom from hunger is a "prerequisite to enjoyment of the other freedom," we are beginning to hear the cry that adequate food supplies for India are essential for the survival of democracy. Pass the checkbook please so we can pay more taxes.

Anderson Assistant Editor of Journal

William Anderson, formerly associate editor for a clinical medicine publication, has been appointed assistant editor of the Illinois Medi-



William Anderson

cal Journal replacing Miss Martha Dana, effective February 23.

A graduate of Marquette University with a B.S. in journalism, Anderson also completed three years of pre-medical studies. He started his career in medical journalism as medical writer for

G. D. Searle & Co., in 1957. After that he was associate editor for *Clinical Medicine Publications* and copy director for Milton G. Peterson Advertising Agency.

His diversified background and proved skills in the field of medical journalism make him ideally suited for producing an ever better ILLINOIS MEDICAL JOURNAL.

He is a native of Milwaukee; he moved to Northbrook, Illinois with his wife and children in 1957.

— Correspondence —

PKU Testing in Illinois

[Editor's Note: This excerpted letter is in reply to a query regarding testing infants for phenylketonuria (PKU).]

... I took the liberty of discussing this matter with Dr. Donaldson Rawlings of the State Department of Public Health. Based upon this conversation I have the following information for you.

It is believed that one state has enacted

legislation imposing a duty upon physicians as a matter of law to make a test for phenlyketonuria. Either that or there is some money grant program under way, under which some state agency has adopted rules and regulations requiring compulsory testing as a condition of the grant. In addition, it appears that lawsuits have been started in the State of New York against physicians for malpractice on the theory that the medical knowledge concerning this matter is now sufficiently widespread so that physicians may be charged with such knowledge. Of course, the lawsuits allege that the infant was not tested, resulting in mental re-

tardation or mental illness.

The State Department of Public Health has undertaken to spread this medical knowledge in Illinois through its publications and through the article by Dr. Daniel Pachman which was recently published in the Illinois Medical Jour-NAL. The Department apparently has found that a child at the age of six weeks and three months may be tested for phenylketonuria by means of a urine test. The Department is not in favor of legislation on this matter, and I can say on behalf of the Illinois State Medical Society that our policy has always been against lay or legislative interference in medical decisions. Education would seem to me to be the proper manner in which to spread medical knowledge.

I think that I have said enough to give you some idea of the legal problem involved. The question will arise, at what point can the individual physician be held accountable for this medical knowledge in a malpractice suit? I would suspect that at this time the knowledge is not sufficiently disseminated to hold the physician negligent who does not test for phenylketonuria.

At the present time the Department is trying to keep track of every known case and is conducting a surveillance of newborn children in the family to make sure that the child or children are tested. In this way the department is attempting to protect the physician.

I hope that this information will be helpful to you.

Sincerely yours, Walter L. Oblinger General Counsel Dear Dr. Van Dellen:

I wish to commend Arthur R. Marks, M.D., president, and Charles J. Jannings, M.D., secretary of the Wayne County Medical Society for their accomplishments in the practice of their art.

It is apparent that they are satisfied with what they have done, what they are now doing, and what further improvements they would like to do in the future in the practice of medicine. It is also apparent that their interpretation of what public health is, what it portends, and what its hope and desires are is based on misunderstanding, rather than just plain ignorance, avariciousness or stubbornness. As they are probably aware, health is a state of complete physical, mental, and social well-being, and public is people.

Now certain people educated in certain aspects, either through schooling, through experience or a combination thereof, in the professions, humanities, or the arts, are dedicated in certain ways toward accomplishing the most good for the many in a manner that bespeaks of aesthetic values rather than materialistic gain.

Public health does not desire, nor is it contemplating, to usurp the life and ways of the practicing physician. Its only motivation is to assist the physicians and dentists in the fulfillment of a more complete coverage of the people. Public health programs are coordinated with the physicians, with the schools, with voluntary agencies and civic bodies, so that their mission of promoting good health by preventive and control measures can be best carried out. People who are trained in public health work, and there are a great many, are better educated academically or experience-wise than many of the physicians who are in the practice of medicine.

These public health people are a dedicated lot whose main objective is to aid, insure, and protect the people of a community in the procurement of health. Health workers, in a sense, possess a culture exclusively their own, and by virtue of their specialized training and knowledge of health, they have a bias which predisposes them to place a disproportionate empha
(Continued on page 289)

Letters Cite Distortions in 'Post' Editorial

Letters of rebuttal to Robert E. MacNeal, president, Curtis Publishing Company, publishers of Saturday Evening Post, cite misstatements and distortions in the editorial, "The Doctors and the AMA"; Saturday Evening Post, February 3, 1962, p. 72. Replies from H. Close Hesseltine, M.D., Chicago and Charles P. McCartney, M.D., Chicago are reprinted herewith.

February 16, 1962

Robert E. MacNeal, President Curtis Publishing Company Philadelphia, Pennsylvania

Dear Mr. MacNeal:

Your Saturday Evening Post issue of February the 3rd contained an editorial to which I wish to take sharp exception.

First let me identify myself. I am a full time salaried professor in the medical school of the University of Chicago. I have been concerned with clinical medicine, medical research, and medical education for my entire professional career (over 30 years). Because of postgraduate lecturing and medical meetings, I have first-hand information from various parts of the country about medical needs.

In the instance of your editorial, gross misrepresentations and deceptions are advanced. One might in a base sense call them lies. There is no evidence that there has been any reduction in the quality of medical students admitted to medical colleges. This is judged by their aptitude scores, by their school performance and subsequent performance. This is a matter of record, not hearsay. It is true that the numbers applying are reduced, but part of this has been "self-selection." Competitions and attractions to other sciences have taken some from us.

Another error deals with the statement that the American Medical Association has opposed various forms of insurance and group practices. The AMA has not opposed these nor the principles, but has been insistent that these be properly designed and administered in the interest of the public. This forthright position is sound statesmanship on the part of the AMA. These efforts are directed to assure the recipients of proper medical care.

I will not enumerate or offer a rebuttal on all of the other repeated misstatements. It is my intention to expose the incompetence or lack of information of the writer of the editorial.

The thoughts in the editorial sound like those emanating from a particular branch of the government. The attitude that the public has lost respect for the profession is a doubtful statement. If this evaluation is made on the basis of the increase of the number of medicolegal suits, then business, government units, editors and publishers, radio and TV personalities, public transportation, schools, automobile drivers, dentists, attornies, and all others are in less favor.

Does this mean the publishers and editors and the rest are less honorable? Is this not a change in the attitude of the public? Is this not a matter of the public becoming suit conscious?

It is terribly disappointing to see the Saturday Evening Post resort to this type of editorial. The technique of repeating falsehoods or of "smear and falsehood" causes some readers to ultimately believe. Certainly we are living in a "troubled" world. It is not helpful to resort to dishonest labeling and name calling. One might wonder, has your editor lowered his standards, or is he in such a desperate situation that he must resort to this method?

Yours truly, H. Close Hesseltine, M.D.

Dear Mr. MacNeal:

The editorial, "The Doctors and the A.M.A." appearing in the current issue of the Saturday Evening Post is not in keeping with the magazine's previous high standards. This article contains half-truths, misstatements of fact and unwarranted assumptions. I will not belabor you

with a detailed list of inaccuracies but cannot resist the temptation of citing some.

The statement "Lamentably the A.M.A. has done precious little in our lifetime to make us patients feel that medicine is on our side" is contrary to fact. The A.M.A.'s numerous current activities and major accomplishments in providing better health care for the people of the United States are outlined in an eighteen page brochure available at the Association's offices. It is surprising that an editorial writer, employed by the *Saturday Evening Post*, would fail to familiarize himself with the activities of the organization.

The statement "The A.M.A. opposed all kinds of group practice" is incorrect. It has opposed only closed panel group practice. "Voluntary Clinics" was erroneously employed as synonymous with group practice to give the unwarranted impression that the A.M.A. was opposed to a method of practice which is of great value to the patient.

It is inconceivable that the *Saturday Evening Post* would publish the obvious untruth, "The doctors as a group have in essence been against almost everything that America is for . . ." This implies that doctors are against the four freedoms, marriage and the sanctity of the home.

The editorial concluded by calling on the members of the A.M.A. for "responsible statesmenship." The members of the A.M.A. likewise might be justified in calling upon the *Saturday Evening Post* for responsible journalism.

Sincerely yours, Charles P. McCartney, M.D.

— Correspondence —

(continued from page 287)

sis on the value of health to life as a whole. They attempt to project this into the lives of people who have other values they hold equally or more important. Unlike health workers people do not, for the most part, separate health and health practices from their total life pattern.

Health workers know that individuals need to be healthy as a condition of attaining their life goals and should, therefore, concentrate on helping individuals achieve better health through motivations and goals in life which they already value.

It is my considered opinion that the people should be allowed to vote, to make up their own minds, to accept or not to accept a county health department. When accepted, the boards of supervisors, elected by the people, have the right to appoint the board of health (eight members), two of whom shall be physicans, one a dentist, and one a supervisor. The cost of the health department, its facility, personnel, and equipment would cost each person the approximation of the price of five packages of cigarettes per year. The tax rate per real estate evaluation cannot exceed \$.05 per \$100 or \$.50 per \$1,000, and the rate can be determined yearly.

The people once "voting in" a health department, if not satisfied, can vote it out too. A county health department, or multiple county health department, will be an advantage, rather than a disadvantage, in carrying out the fulfillment of good lasting health improvement for all of the people and even perhaps that laggard 5 per cent. Give it a try. You won't be sorry. You will be glad that you changed your mind.

Matthew J. Hantover, M.D. M.P.H., F.A.P.H.A. F.A.A.C.P. (Emeritus)

Dear Mr. Kinney:

We would like to point out that some of the information contained [in Reference Page #27 on Skin Test Materials] is in error as pertains to Lederle skin test antigens.

We do not now produce a Ducrey Test for Chancroid or a Foshay Test for Tularemia. In addition, Lederle is not listed for (although we do make) skin test antigens for Lymphogranuloma Venereum, Polligens for Eastern and Western Mixed Grasses and Ragweed, House Dust skin test and, of course, Smallpox Vaccine.

Sincerely yours, Robert A. Baker Product Group Advertising Manager Lederle Laboratories



DRUG INFORMATION CENTER

The first service center for emergency drug information for the nation's physicians was put into operation January 8. Conceived and operated by physicians, the service, called Mediphone, is a drug information center located in Washington, D.C. It is capable of supplying detailed data instantaneously on any one of the more than 8,000 drugs in use today. Any member physician in the country, faced with an emergency or wanting to know more about a drug he wishes to use, can obtain all the information he needs any time of the day or night by telephone.

According to Dr. Cortez F. Enloe, Jr., president and founder, Mediphone will soon become the nation's primary source of data on drug therapy. "The information that Mediphone stores for doctors was gathered by a research team of physicians, biochemists, pharmacologists, pharmacists, and toxicologists. They studied official compendia, textbooks, manufacturers' data, and medical periodical literature covering a 15-year period. This mass of data was then arranged in manageable form with the aid of the most modern data-handling and retrieval techniques and equipment furnished by the Remington-Rand, IBM, and Bell Telephone companies. The data will be kept current with the assistance of the department of pharmacology of George Washington University Medical School, the College of Pharmacy of Long Island University, a team of medical librarians searching more than 200 medical journals each month, and with official reports from the American Medical Association."

The cost of membership is \$20 a year. The member is then assigned a registry number and issued a permanent card bearing that

number. Any hour of the day or night when a physician places a call to Mediphone, he states his registration number and the questions to be answered. Within a matter of seconds, the Mediphone responder—always a physician—gives the answer. Within twenty-four hours after the call is completed, Mediphone mails the member physician a report of his inquiry for his case records. Verbatim transcripts of the call are also available if needed.

PHARMACEUTICALS

Alphadrol is Upjohn's new steroid that is claimed to be two and one half times as potent as prednisolone and generally produces "dramatic and rapid" suppression of symptoms in diseases known to respond to such drugs. It is anti-inflammatory and antiallergic; side effects are said to be minimal. In regard to the potency of a drug, physicians should remember that decreased milligram dosage of a new drug means very little unless the therapeutic effects are maintained at the same time the side effects are reduced or eliminated.

Abbott Laboratories have introduced Ioquin suspension (diiodohydroxyquin), a "safe new preparation, as easy to use as shampoo, for control of dry and oily dandruff." According to Abbott, it controls dandruff in more than 95 per cent of cases when applied once or twice weekly. It is relatively nontoxic.

A double-layered tablet developed by Reed & Carnrick is the current gas reliever. The outer layer contains pepsin, diastase, and polysiloxane, a defoaming agent. The inner layer contains the enzyme pancreatin with polysiloxane. The news release on the drug quotes an article in

the American Journal of Gastroenterology in which three out of four patients were relieved of gaseous discomfort. No controls were used in the study.

Ananase is Rorer's new orally administered proteolytic enzyme. It is a concentrate of the bromelains found in pineapple plants. It was designed, according to the manufacturer, to reduce inflammation and edema, ease pain, speed healing, and accelerate tissue repair. Oral proteolytic enzymes are difficult to evaluate; large doses usually are necessary, and best results are obtained when they are given before the production of the inflammation.

Winstrol is Winthrop Laboratories' new anabolic or tissue-building steroid. According to their news release, "Dramatic results have been obtained in building up undernourished individuals of all ages. By doing so, weak and debilitated people have acquired confidence, alertness, and a sense of well being.

"The new drug has proven especially useful to undernourished, listless children; adolescents who are persistently underweight; preoperative and postoperative patients; victims of rheumatoid arthritis; persons with chronic wasting diseases, . . . and to old people who have no appetite."

WHAT'S NEW

A do-it-yourself urine pregnancy test is now being distributed throughout the world by the Leyden Laboratories of One Bala Ave., Bala Cynwyd, Pa. The president of Leyden, Martin Miller, claims that the "RVG" pregnancy test gives accurate results in minutes. But don't take your editor's word for this.

A new externally controlled cardiac pacemaker was introduced by the x-ray department of General Electric. This unit does not stimulate the heart from outside the body nor does it have implanted electrodes coming out of the body. The electrodes and the unit are implanted within the chest cavity or abdomen. The only part outside the body is the component that electronically changes the pulse rate. This small offshoot or spur from the pacemaker allows the individual to increase the



HEART-STIMULATING signals are produced in General Electric's new cardiac pacemaker by an oscillator, held at left, and are conducted by teflon-coated wires to terminals imbedded in the heart muscle. These elements of the unit are wholly implanted within the patient's body. An external remote control component, complete with induction coil, can electronically change the pulse rate of the oscillator.

pulse rate on occasions when engaging in strenuous activities. The implantable pacemaker uses simple circuits with highly reliable solid state devices as active components and batteries with lives of three to five years.

MIKROS, Inc., has introduced a new external, ac-type cardiac defibrillator. It is a compact portable instrument that is easy to operate and maintain. The pistol grip electrode features push-to-actuate dual safety buttons conveniently located in the electrode handles.

Kool Kit is a new molded plastic case for carrying insulin, needles, and syringes during travel. The lightweight unit is lined with styrofoam to protect the insulin from heat. The Kool Kit Corporation recommends that the diabetic refrigerate overnight the entire kit with supplies in place before leaving on a trip.

Crouse-Hinds Company recently marketed a new portable electrical receptacle unit with three explosion-proof outlets instead of one. It is designed for hospital operating rooms where anesthetics and other explosive gases are used. The new EHRO units triple the outlet capacity of existing explosion-proof wall reEditor's Desk (continued)

ceptacles and handle any three pieces of apparatus equipped with type EHP plugs.

Brewster, Inc., makers of Polecat I.V. stands, bed screens, and "Pick-Me-Up" patient aids has developed a new "wall-to-wall" screen especially designed for doctors' offices, outpatient clinics, and patients' rooms. The springloaded, telescoping Polecat is adjustable and can be sprung into place to span an area to be screened. Sounds good, but what names for patient aids!

Remington Rand has a new microfilm camera that is so fast and precise that it photographs both sides of a document simultaneously at the rate of 125 paper feet a minute. This Film-A-Record 555 camera is no bigger than a portable TV set.

DRUG THERAPY FOR CANCER

Scientists at the Public Health Service's National Cancer Institute have been making discoveries about the blood supply of tumors which may be of great importance to the drug treatment of cancer.

About 20 drugs effective against some 30 forms of cancer are now available to physicians on prescription; only one of these is credited with cure. A few women with a rare but severe form of cancer occurring in connection with pregnancy, who were treated at the institute with a drug called methotrexate, have survived for five years or longer without evidence of disease.

EXILED CUBAN PHYSICIANS

The following is excerpted from a January communication of the American Hospital Association to hospital administrators:

"During recent months many Cuban physicians have escaped to the United States. The greatest concentration . . . is in Florida, Miami mainly. Because . . . most . . . left Cuba with few or no financial assets, their economic situation is perilous.

"The Cuban physician escapees have formed the Cuban Medical Association in Exile. Enrique Huertas, M.D., serves as president of the association, which is located at 213 Aragon Avenue, Coral Gables, Fla., P.O. Box 1016.

"Doctor Huertas has made a request for any assistance or cooperation which the American Hospital Association may provide in placement of Cuban physicians in hospitals.

"Recognizing the plight of these exiles, we encourage employment of these Cuban physicians wherever legitimately possible and praetical. However, hospitals cannot afford to jeopardize their standards of medical and patient care by employment of unqualified Cuban physicians in exile in positions where direct patient eare responsibility must be exercised. The standards and requirements of the Educational Council for Foreign Medical Graduates, listing by the American Hospital Association, accreditation by the Joint Commission on Accreditation of Hospitals, and approval for internships and residencies by the American Medical Association should not and have not been waived for these exiles."

PAMPERED PUPS

The dog population of this country is now in excess of 26 million. They have at their service some of the finest minds in dentistry, virology, biology, and medicine. And why not? The American dog-owning public spent more than a half billion dollars during a recent year for the care and service of "man's best friend." Seventy per cent of this was spent on 2½ billion pounds of dog food; leashes, collars, and grooming aids cost \$25,000,000, and another \$35, 000,000 was spent on dog licenses. Canine dentistry includes several technics which are done under anesthesia. The nutritionists play a major role in keeping Rover happy and healthy. Throwing him a bone or filling his plate with leftovers is passe. The modern dog owner watches calories, adds calcium to the puppy's or gestating dog's dict, and regulates vitamin intake. Dogs also have a choice of tidbits flavored with beef, veal, chicken, or liver.

They get the same antibiotics as humans when ill, and their distemper has been inoculated almost out of existence. We also are having a canine population explosion, which won't help us city fellas one bit.



Number 29

By County (exclusive of Cook)

Adams

Comp Point Comp Point Convalescent Home Igcobs Nursing Home Maplawood Nursing Home

Padgstt Nursing Home Box 166

Quincy

Boll Nursing Home 1029 Jersey St. Cookson Nursing Home 223 N. 10th St. Dyer Nursing Home 321 N. 4th St.

Eloise Nursing Home 1614 N. 4th St. Hall Nursing Home

1870 Vermont St. Parker Nursing Home 431 Locust St.

St. Josephs Nursing Home 1315 N. 8th St.

Theda Boll Nursing Home 438 N. 12th St.

Bond

Grsenville

Smithboro

Bourgeois Nursing Home 100 W. College St. Pacatte Nursing Home 102 E. College St.

American Nursing Home

Boone

Belvidara

Suttons Nursing Home 226 N. State St. Maple Crest Nursing Home Boone County Home RR No. 1, Route 76

Brown

Mt. Sterling Barkers Nursing Home 204-206 Railroad Ave. Haleys Nursing Home 401 W. Main St.

McClelland Convalescent Home 212 W. Main St. Padgett Nursing Home, No. 2

117 East South St. Whited Nursing Home 308 N. Capitol St.

Bureau

Princeton

Prairieview Nursing Home RR 5

Calhoun

Hardin

Montreat Nursing Home RR No. 2, Box 152

Carroll

Milledgeville

Milledgeville Nursing Home 600 Main St.

Mt. Carroll

Mt. Carroll Nursing Home, Inc.

Savanna

Panacea Convalescent & Nursing Home 316 Chicago Ave.

Shannon

Johnsons Nursing Home

Cass

Beardstown

Boyd Nursing Home 209-215 W. 3rd St. Brierly House Nursing Home 604 State St. Parkview Nursing Home

Virginia

Kirkpatrick Nursing Home 145 N. Front St. Walker Nursing Home 530 E. Beardstown St.

903 E. 3rd St.

Champaign

Champaign

Cole Nursing Home 1102 W. Church St. Laymon Convalescent Home 702 W. University Ave. Leonard Nursing Home 618 W. Church St. American Manor

Convalescent Home

1002 W. Church St.

Urbana

Champaign County Nursing Home 1701 E. Main St. **Hubert Nursing Home** 505 W. Green St.

Christian

Morrisonville

Memorial Nursing Home

Depaepe Ashcraft Nursing Home 10 S. Oak St.

Taylorville

Dexheimer Manor Route 48 North Dexheimer Nursing Home 216 E. Franklin Smiths Guest Home 305 E. Adams Taylorville Nursing Home 405 N. Silver St.

Clark

Martinsville

Glendening Nursing Home W. Washington St.

Casey

Rudes Goodwill Home 208 W. Main St.

Clay

Cottengaims Nursing Home 221 E. 3rd St. Raber Nursing Home 402 E. 4th St.

Hill Crest Nursing Home Chestnut St.

Coles

Charleston

Adkins Nursing Home 849 C St.

Charleston Nursing Home 216 5th St.

Hilltop Nursing Home, Inc. 635 Division St.

Oakwood Convalescent Home 1041 7th St.

Rennels Nursing Home 214 5th St.

Wilson Kaley Nursing Home 1501 18th St.

Cunningham Nursing Home 1312 Wabash Ave.

Crawford

Robinson

Robinson Nursing Home 503 E. Main St.

De Kalb

De Kalb

De Kalb County Nursing Home Sycamore Road, RR No. 23

Sandwich

Sandhaven, Inc. 517 N. Main St.

Genog

Villa Rest Home 121 Main St.

Waterman

Bellevue Place 310 N. Elm St.

De Witt

Clinton

Pine Crest Nursing Home North Center Limits De Witt County Nursing Home RR No. 1

Farmer City

Farmer City Nursing Home, Inc. 326 Clinton Ave.

Douglas

Arcola

Arcola Nursing Home 112 S. Locust St. Fishel Nursing Home 129 N. Pine

Tuscola

Martin Nursing Home 114 E. Daggy St.

Villa Grove

Maple Rest Home 710 E. Elm St.

Du Page

Bloomingdale

Mark Lund Hilltop, Inc. 158 Prairie St.

Downers Grove

Woodridge Nursing Home, Inc. 35th St. near Highland Ave.

Elmhurst

Sunnybrook Nursing Home 16 W. 541 Butterfield Rd.

Griffith Nursing Home Garfield St. & Plainfield Rd.

The Oaks Nursing Home Rt. No. 83 & 91st St.

Shanks Rest Home 525 W. Ogden Ave.

Naperville

Brentwood Nursing Home 134 N. Washington St.

Villa Park

Acre View Nursing Home, Inc. 538 S. Villa Ave.

West Chicago

Hazelhurst Farm Roosevelt & Gary Mill Rd. Morton Manor Health Home RR No. 1, Box 753

Du Page County Convalescent Home County Form Rd.

Wheaton Health Resort, Inc. 1325 Manchester Rd.

Winfield

Zace Retirement Home 27 W. 141 Liberty St.

Wood Dale

Wood Dale Nursing Home 140 Hemlock

Edgar

Chrisman

Watson Nursing Home 109 E. Monroe

Edwards

Albion

Rest Haven Nursing Home 130 W. Main St.

West Salem

Gaedes Nursing Home Maple Park Nursing Home N. Albion & Church Sts.

Effingham

Effingham

Marks Nursing Home 406 E. Jefferson St.

Fayette

St. Elmo

Marks Nursing Home 317 Cumberland

Vandalia

Fayette County Hospital Annex 727 W. Jackson Favette County Nursing Home RR No. 3

Rose Haven Nursing Home 117 S. 7th St.

Ford

Gibson City

Gibson City Convalescent Home 415 S. Lott Blvd.

Williams Nursing Home 315 N. Guthrie St.

Ford County Nursing Home RR No. 2 Lyons Nursing Home 440 E. Pells St.

Franklin

Benton

Linwood Nursing Home N. Main & Mitchell Sts. Rest Haven Nursing Home 418 W. Webster

Fulton

Conton

Canton Nursing Home, Inc. N. Main St. Sherwood Nursing Home

914 S. Main St. Sherwood Nursing Home, No. 2 203 W. Locust

Farmington

Harmony Haven Nursing Home 365 E. Fort St.

Lewiston Stephens Nursing Home

305 S. Main St. London Mills

London Nursing Home

Greene

Corrollton Tower View Nursing Home No. 2 626 Maple Ave.

Greenfield

White Hall

Cedar Knoll Nursing & Convalescent Home 711 Bluff St.

Grundy

Hill Top Haven

Morris

Deng Ericksons Nursing Home 916 Fremont Ave. Grundy County Nursing Home

McCarthy & U.S. Rt. 67A

Hamilton

McLeamsboro

RFD 4

McLeansboro Nursing Home 205 E. Cherry St.

Hancock

Augusta

Margaret Ranck Nursing Home E. Moin St.

Carthage

Margaret Ranck Nursing Home 140 W. Main St.

Plymouth

Myrtle Sapps Nursing Home Main St.

Henry

Jehling Nursing Home 400 N.W. 4th Ave. The Wasson Nursing Home 309 N.E. 1st St.

Geneseo

Graderts Nursing Home 426 W. 1st St. Henry County Convalescent Home RR No. 4

Kewanee

Park View Home 210 N. Vine St. Sunnyslope RFD No. 1 Cambridge Rd.

Iroquois

Beaverville

Haven of Rest

Ongraga

Jones Nursing Home 317 N. Walnut St.

Happy Siesta Nursing Home 220 E. Center St.

The Iroquois Resident Home 830 S. 4th St.

Iackson

Murphysboro

Dillow Nursing Home 316 N. 9th St. Jackson County Nursing Home 1441 N. 14th St.

Tyler Nursing Home 1711 Spruce St.

Tefferson

Bluford

Schumm Nursing Home

Ina

Underwood Nursing Home 3 Elm St.

Mt. Vernon

Lowrys Nursing Home 1304 Main St. Setzkorn Nursing Home, Inc. 1300 Broadway

Jersey

Jerseyville

Garnet Nursing Home 602 W. Pearl St.

Green Lawn Nursing Home 518 S. State St. Waters Nursing Home 408 N. Giddings St.

Io Daviess

Apple River

Hicks Nursing Home Walnut St.

Galena

Sunny Hill Nursing Home 513 Bouthillier St.

Stockton

Morgan Memorial Home 501 E. Front Ave. Morgan Nursing Home 205 E. Benton Ave.

Warren

Daters Nursing Home Water St.

Lahev Nursing Home Burnett St.

Sunnyside Nursing Home 206 Lions St.

Kane

Aurora

Colonial Nursing Home 422 N. Lake

Galena Blvd. Nursing Home 1017 Galena Blvd.

Batavia

Kane County Home Averill Rd.

Bowes Nursing Home, Inc. 305 Oregon St. Gregg Nursing Home 417 E. Hill St.

Elgin

Daybreak Nursing Home 420 Douglas Ave.

Elgin Bowes Nursing Home, Inc. 105 N. Gifford St.

Elgin Rest Home 304 South St.

Hillcrest Convalescent Home, Inc. 4 N. Jackson St.

Isabelle Rest Home 104 S. State St.

Little Angels Nursing Home 330 Watres Place

Marys Hill Rest Home 309 Watch St.

Mary Margaret Manor, Inc. 134 N. McLean Blvd.

The Oliver Nursing Home 325 Watch St.

The Park View Nursing Home 731 Linden Ave. - (Cook Co.)

Raloff Rest Home 316 Division

Restville House 443 E. Chicago St.

Woodlawn Nursing Home 705 Highland Ave.

Geneva

Anna Baum Home 115 Campbell St. Marion Manor Nursing Home 28 N. 1st St.

Hampshire

Lydia Nursing Home 25 W. Jackson St.

St. Charles

Valley Rest Home 309 S. 6th Ave.

Kankakee

Aroma Park

Campbell Nursing Home Box 271, 4th St.

Kankakee

Bethel Nursing Home 210 N. Harrison Ave. Casper Nursing Home, No. 2 480 E. Oak St.

Deerwood Convalescent Home RFD No. 5, Aroma Park Rd. Eventide Home, Inc. 1151 E. Court St.

ldle A While Nursing Home 124 N. Maple

Kendall

Plano

Wesley Haven Nursing Home 218 N. Center St.

Knox

Galesburg

Glendening Nursing Home 490 N. Cherry St.

Harvey Nursing Home 774 N. Broad St.

Powell Nursing Home 620 S. Academy

Sheltering Arms Nursing Home 618 Michigan Ave.

Wiegand Nursing Home 731 N. Seminary

Knoxville

Good Samaritan Nursing Home 407 N. Hebard St. Knox County Nursing Home

St. Marthas Nursing Home N. Market St.

Lake

Highland Park Abbott House 405 Central Ave.

Lake Bluff

Hill Top Farm 502 N. Telegraph Rd.

Lake Villa

Hampstead House Rt. No. 1, Box 45 Lake Villa Nursing Home P.O. Box 87, Cedar Ave. Venetian Manor Convalescent Home Rt. No. 2 on Rt. No. 132

Lake Zurich

Bee Doziers Maple Hill Nursing Home, Inc. P.O. Box 288

Libertyville

Lake County Nursing Home 1125 N. Milwaukee Ave.

Wayside Home 214 W. Park Ave.

Mundelein

Pine Manor Rt. No. 1, Box 185 Half Day Rd.

Redels Nursing Home 923 Shiloh Blvd. Zion Nursing Home 2561 Sheridan Rd.

La Salle

Ottawa

Hassleys Health Haven Gentleman Rd., RFD No. 4 Hayes Nursing Home 427 E. Main St.

Highland Sanatorium and Convalescent Home of La Salle County 800 Center St.

Susie H. Moore Rest and Healing Home 627 3rd Ave.

Peru

Tri City Nursing Home 2804 6th Ave.

Rutland

Rutland Nursing Home, Inc. Front & Chestnut Sts.

Streator

Cheery Rest Nursing Home 407 E. Hickory St.

Star Haven Convalescent and Nursing Home 405 N. Wasson St. The Edgetown Richards & Chicago Sts.

Dyer Nursing Home 2nd & Elm Sts.

Lawrence

Lawrenceville

Knight Nursing Home 1509 12th St. Shidler Nursing Home

1022 12th St.

Sumner Milligan Nursing Home

Railroad St. Polands Christian Nursing Home 201 W. South St.

Lee

Amboy

Forman Nursing Home 339 N. Mason Ave.

Dixon

Lee County Nursing Home RR No. 4 The Mansion Nursing Home 403 E. Fellows St.

Rest Haven Convalescent Home 204 E. 3rd St.

Livingston

Fairbury

Mae F. Harris Home 410 E. Oak St.

Pontice

Livingston County Nursing Home RFD No. 1

Logan

Atlanta Atlanta Nursing Home

In a successive issue of the Journal the list of licensed homes by county will be completed.

Bartmann Nursing Home Lincoln Deaconess Memorial Home 302-330 7th St. Wasson Nursing Home 1011 3rd St. Mary Henry Convalescent Home

313 Willard Ave. McDonough Blandinsville

Newland Nursing Home

Bushnell The Elms McDonough

County Home Heron Nursing Home 708 N. Dean St.

Colchester

Helion Nursing Home S. East St.

Prairie City

Westfall K & C Nursing Home Reed & Union Sts. Westfall Nursing Home

McHenry Hartland

Valley Hi Nursing Home for McHenry County

Harvard Harvard Rest Home 210 E. Front St.

Marengo Florence Rest Home

546 E. Grant Hwy. McHenry

The Villa Nursing Home 1201 W. Rocky Beach

Woodstock

Birchwood Rest Home RR No. 1 Woodstock Residence

309 McHenry Ave.

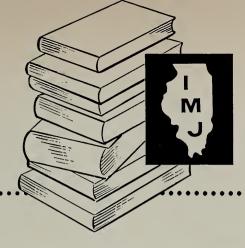
The assistance of the Division of Hospitals and Chronic Illness, Department of Public Health, State of Ministra greatly appreciated.

Chatham St.



nois Medical Journal MARCH, 1962

Book Reviews



Hypertension — Recent Advances, The Second Hahnemann Symposium on Hypertensive Disease. Albert N. Brest, M.D., and John H. Moyer, M.D. \$12. Pp. 660. Philadelphia, Lea & Febiger, 1961.

The Second Hahnemann Symposium on hypertension is essentially an up-to-date textbook on hypertensive vascular disease edited by Drs. Albert N. Brest and John H. Moyer and authored by 117 of the foremost authorities in the investigative and clinical field of hypertension.

In December, 1958, the First Hahnemman Symposium on hypertensive disease was held in Philadelphia. Enough significant new data has been accumulated in the past two and one-half years to warrant academic reconsideration of the subject resulting in the Second Hahnemann Symposium and subsequent volume.

This volume represents the papers presented at the symposium and the verbatim transcriptions of the panel discussions. For the first time in any large symposium, the epidemiologic possibilies of hypertension are considered along with the natural history of the disease. All the known etiologic mechanisms in essential hypertension are again reviewed and discussed, but the cause of increased peripheral resistance in essential hypertension remains as mysterious as ever. Significant advances have been made, however, in the past three years in the relationship of atherosclerosis to hypertension; these are particularly in the realm of renal-vascular atherosclerosis, its diagnosis, and its surgical treatment.

Pharmacology of the newer hypertensive drugs has been further explored resulting in a much better understanding of the hypotensive and hemodynamic effects of the thiazides—chlorothiazides and monamine oxidase inhibitors. Major achievements in the past few years have included newer detailed knowledge of the metabolism of the pressor amines and

their relationship to salt, water, electrolytes, and newer hypotensive drugs.

Much of this volume has to do with the most recent therapeutic considerations in the treatment of hypertension. Several individual methods of treatment are described both for the ambulatory patient and for the patient with hypertensive crises of various etiologies. Treatment includes the surgical approaches, that is, sympathectomy and adrenalectomy.

Although greater strides have been made in the past decade in the control of hypertensive disease than had been made in the previous 50 years and potent hypotensive drugs are available, the etiology of essential hypertension is still elusive and potent hypotensive drugs are still far from perfect. Dr. Horace Merk of New Zealand best describes them as "gravity augmented hypotensive drugs." The disease is better controlled with the patient in an upright than in a prone position, and side effects are disconcerting to say the least. Newer experimental drugs as presented in this symposium seem to offer nothing additional to the drugs that are now available to the practicing physician.

For the student of hypertension, for the internist and general practitioner, this is an excellent, up-to-date volume on the present status of hypertensive-vascular disease. The panel discussions transcribed verbatim at the end of each section could best be presented as a digested summary. This volume incorporates a great deal of the work that has been written about this subject during the past five years by the greatest authorities in the field. It delineates extremely well those hypertensive patients who should be treated as well as those who should not be treated and outlines the proper course of treatment to follow by the active practitioner of medicine.

Howard A. Lindberg, M.D.

for March, 1962 303

RESPIRATION, PHYSIOLOGIC PRINCIPLES AND APPLICATIONS. Edited by P. H. Rossier, M.D., et al. Translated by Luchsinger, M.D., and Moser, M.D. \$15.75. Pp. 505. St. Louis, The C. V. Mosby Company, 1960.

This is an important review of cardiopulmonary physiology. There is widespread current interest in this field as judged by textbook sales, registration at postgraduate courses, and attendance at medical meetings. Drs. Luchsinger and Moser have not merely translated the original text by Dr. Rossier and his collaborators but have exercised considerable editorial privileges. This they are well equipped to do as they have both had the enviable opportunity of intensive cooperative participation in the clinical and laboratory activities of Dr. Rossier's group. This association has provided the editors with an understanding of the differences between domestic and European concepts of basic physiology and their clinical applications. It is both interesting and beneficial to be informed, via footnotes and otherwise, wherein these specific differences exist.

This text is divided into four parts: (1) "Normal Physiology of Respiration," (2) "Investigative Methods in Pulmonary Function," (3) "Pathophysiology of Respiration," and (4) "Pulmonary Insufficiency in Clinical Practice." An appendix is included and consists of nine pages of equations, correction factors, commonly used reagents, and related material plus an extensive bibliography of 80 pages containing approximately 2,500 separate references.

Comprehensive and detailed as this text is, some subjects are inadequately covered and emphasis improperly directed, at least in relation to clinical significance. For someone interested solely in physiologic principles such criticism is inappropriate. Ventilatory function and its measurement receive brief consideration. Since there are several excellent reviews of this particular aspect of lung function, perhaps its exclusion is relatively unimportant. This book does contain a large amount of material on pulmonary mechanics and various methods for measuring the mechanical properties of the lungs. This indirectly suggests such measurements are superior to conventional ventilation tests for clinical use; this would be erroneous. The section dealing with the clinical aspects of altered lung function is organized in such a manner that the physiologic changes receive primary consideration and their relation to specific diseases is noted secondarily. This section is thus somewhat less valuable to the clinician mainly concerned with a disease entity who wishes to learn the physiologic bases for its clinical expression. An extremely helpful aspect of the clinical section is the liberal presentation of extensive results of laboratory studies in specific cases. This affords the reader an opportunity to "second guess" the experts regarding the interpretation of laboratory data.

The appendix deserves special mention. Unfortunately the tables of normal values, reagents, correction factors, etc. are incomplete and, unless identical analytic techniques are utilized, of dubious assistance to the physician in charge of a laboratory. The bibliography is unquestionably the most extensive review of the literature in this field currently available in English. It is organized along different lines from the text and divided into various topics that do not correspond to the topics in the main body of the book. In the text the references are cited by author only, whereas each section of the bibliography is listed alphabetically. Thus it is often necessary to look for a specific reference in several different places within the bibliography. There are frequent unnecessary duplications, particularly where a reference to an abstract of a particular work is given and a later, complete publication is also listed. Nevertheless, the bibliography is certainly one of the most valuable assets of this book.

Various minor differences in physiologic and clinical customs are evident, such as expressing work loads during exercise studies in watts, which is not common in this country. Major conceptual differences are explained in greater detail, for example, insufficient contact time within the pulmonary capillary as a basis for impaired pulmonary diffusing capacity.

This is a most valuable reference text and we are grateful to Doctors Luchsinger and Moser for making it available.

David W. Cugell, M.D.



Benylin[®] Expectorant

provides the right combination for effective cough control

Your patient probably has a more "down-to-earth" occupation than the trapeze artist, but persistent coughing can cause a comparable drop in performance. Not so when you prescribe BENYLIN EXPECTORANT. This outstanding antitussive preparation effectively suppresses coughs due to colds or allergy through its combination of judiciously selected ingredients.

Benadryl,® a potent antihistaminic-antispasmodic, calms the cough reflex, relieves bronchial spasm, and reduces nasal

stuffiness, sneezing, lacrimation, other symptoms associated with colds, and coughs of allergic origin. Efficient expectorants break down tenacious mucous secretions, thereby relieving respiratory congestion. And the pleasant-tasting, raspberry-flavored syrup provides a soothing demulcent action that eases irritated throat membranes.

BENYLIN EXPECTORANT contains in each fluidounce: Benadryl® hydrochloride (diphenhydramine

hydrochloride, Parke-Davis) 80 r	ng.
Ammonium chloride 12	gr.
Sodium citrate 5	
Chloroform	gr.
Menthol 0.1	gr.
Alcohol	

Supplied: BENYLIN EXPECTORANT is available in 16-ounce and 1-gallon bottles.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

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PARKE, DAVIS & COMPANY, Detroit 32, Michiga

NEWS of the STATE



Adams County

Dr. Harold Swanberg, Quincy, is the 1962 selection of the Quincy Exchange Club for its Golden Deed Award. He was chosen for his noteworthy and unselfish work for the community during the previous year. The award was presented at a dinner in February.

Dr. Swanberg is the founder of the Society of Academic Achievement, the Mississippi Valley Medical Society, and the American Medical Writers' Association.

Clinton-Marion County

Ground-breaking ceremonies in February launched the construction of the Mentally Retarded Institute at Centralia. The \$11,500,000 institution, to be built on a 120-acre plot located west of Centralia, is expected to be completed in two years. It will accommodate about 750 patients in modern one-story H-shaped resident units in a campus arrangement behind the main buildings.

Cook County

Mental Health Clinic for North Chicago

The site for one of two community centered mental health clinics in Chicago has been selected. It will occupy 66 acres bounded by Irving Park Rd. on the south and Oak Park Ave. on the east and will serve the area north of North Avenue.

Adult facilities allocated are 160 beds for the mentally ill, 20 beds for geriatric patients, and 20 beds for alcoholics, plus an outpatient center.

Children's facilities will have 40 beds for the mentally retarded and 20 beds for the emotionally disturbed, pre-psychotic, and psychotic, with an outpatient program. General children's services will have separate outpatient quarters, with specialists able to give immediate attention at the first signs of disturbance.

Another clinic will also be constructed to serve residents living south of North Avenue.

Appointments

On March 1 Charles R. Goulet, Baltimore, became superintendent of the University of Chicago Hospitals, the 715-bed medical center on the campus. He also is an associate professor of hospital administration in the university's Graduate School of Business.

Goulet, who for the last three years had been associate director of the Johns Hopkins Hospital in Baltimore, succeeds Ray E. Brown, now the university's vice president for administration.

M.D.'s in the News

In February *Dr. John A. Cooper* of Evanston, associate dean of Northwestern University Medical School, began a 10-month tour of Latin American nations lecturing on how to improve teaching methods in medical schools. February 26 he was at El Salvador Medical School for a seminar, and in April he will go to Columbia as a delegate from the Association of American Medical Colleges.

Several area physicans are among the 1962 officers of Phi Lambda Kappa fraternity. Dr. Edwin M. Patlak, Northbrook, is editor of the Quarterly Magazine; Drs. Edward A. Crown, Silas Wallk, and Bertram Levin, all of Chicago, are regional vice presidents; new trustees are Drs. Fred Gilbert and Joseph Stagman, both of Chicago, and Irwin A. Smith, Northbrook.

Chicago's Alpha Alpha chapter received the fraternity's best undergraduate chapter award.

The Chicago Dermatological Society at a

FOR PSORIASIS—ESPECIALLY IN INTERTRIGINOUS AREAS

ALPHOSYL® LUBRICATING CREAM

REMOVES SCALES! REDUCES ERYTHEMA! RELIEVES IRRITATION!

Now! The Clinically Proven
ALPHOSYL Formula in a New Cream Base
that Simulates Natural Skin Lipids!

Marked success in treating psoriasis—especially in intertriginous areas—is reported with new Alphosyl Lubricating Cream.¹ In a study of 96 psoriatics, 73 patients experienced 75% to 100% clearing—15 showed 50% to 75% clearing.¹ Alphosyl Lubricating Cream not only helps remove scales and reduce erythema, but a new cream base affords added lubrication between the skin folds.





Patient E. C. Treatment started Jan. 14. On Feb. 18 clearing is almost complete.

Thus, it prevents the painful irritation that results from the rubbing of lesion against lesion. The base enhances moisture retention and, containing squalane, dissolves a cement substance in psoriatic scale.

Active Ingredients: Allantoin 2% and special coal tar extract (Tarbonis®) 5%.

Supplied: In tubes of 60 Gm.

Important Therapeutic Note: Instruct patient to rub Alphosyl vigorously into the skin.

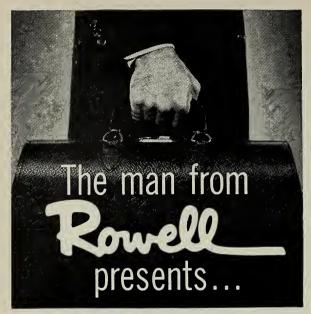
Reference: 1. Bleiberg, J.: Clin. Med. 8:1724 (Sept.) 1961.

For generalized and scalp psoriasis
ALPHOSYL LOTION
For psoriasis—with acute inflammation

ALPHOSYL HC

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VIO-DEX VIO-DEX TIMELETS VIO-DEXOSE

A family of obesity-control aids combining appetite control and nutritional supplementation. Four dosage forms from which to choose; each containing dextroamphetamine with a barbiturate to prevent excessive central stimulation, and vitamins to supplement the restricted diet:

Vio-Dex, introduced in 1950, is now a standard in obesity-control therapy.

Vio-Dex Timelets offer sustained release of dextroamphetamine. One Timelet in the morning lasts all day. Available in 10 mg. and 15 mg. dosage forms.

Vio-Dexose chewable tablets, with dextrose and dextroamphetamine, provide a dual attack on hunger and allow dosage flexibility. Contraindications: Prepsychotic anxiety and agitation, and hypersensitivity to sympathomimetic agents. Use with caution in patients with cardiovascular disease. Side Effects: Seldom encountered, include nervousness and insomnia. (Rx only)

Formulation:	Vio-Dex Red & Yellow Capsule†	Vio-Dex Timelets††	Vio-Dexose Citrus Flavored Tablet†‡
Dextro-			
Amphetamine		10 mg.*,	
Phosphate	5.0 mg.	15 mg.**	2.5 mg.
Phenobarbital	16 mg.	32 mg.	
Mephobarbital			8.0 mg.
Dextrose (9.4 cal			2.5 mg.
Vitamin A	5000 I.U.	5000 I.U.	1000 I. U.
Vitamin D	1200 I.U.	1200 I.U.	100 I. U.
Vitamin B-1	3 mg.	3 mg.	0.5 mg.
Vitamin B-2	3 mg.	3 mg.	0.5 mg.
Vitamin B-6	1 mg.	1 mg.	0.15 mg.
Vitamin C	100 mg.	100 mg.	15 mg.
Vitamin E	1 I.U.	1 I.U.	
Niacinamide	20 mg.	20 mg.	3 mg.
Calcium	_		
Pantothenate	2 mg.	2 mg.	0.3 mg.
*Orange, coated			blets ††1 a day

For more facts, see your local Rowell man or write:

Rowell LABORATORIES, INC.
BAUDETTE, MINNESOTA

January meeting elected *Drs. Harold Shellow*, president; *Harold H. Rodin*, vice president; *Milton Robin*, treasurer; and *Frederick D. Malkinson*, secretary.

Grants

Presbyterian-St. Luke's Hospital has received \$400,000 from Mrs. Tiffany Blake to establish the Albert M. Day Research Fund in memory of her father. Dr. Oglesby Paul, a member of the attending staff, will be the administrator.

Income from the fund will be used to support the work of those who have shown distinction in the teaching and study of diseases affecting the cardiovascular system.

Two grants totaling \$357,000 have been made to the Chicago Medical School for research in metabolism. One, a two-year award of \$90,000, came from the National Science Foundation for investigations into the process by which sugars in the diet are absorbed and passed into the blood stream; the other, a three-year grant of \$267,500, was given by the U.S. Public Health Service for studies of an enzyme (hexokinase) which acts on the metabolism of blood sugar.

Dr. Robert K. Crane, professor of biochemistry and chairman of the department, will direct the studies in the school's new Institute for Medical Research.

Northwestern University Medical School has been given \$400,000 for its Medical Building Fund from the Edward Hospital, Naperville. The gift will be used to establish the Edward Sanitarium Research Laboratories of Microbiology on the sixth floor of the proposed 15-story teaching and research wing of the Montgomery Ward Memorial Building on the Chicago Campus (August Journal).

A major portion of the laboratories will be used for research in tuberculosis, including studies on the mechanisms of streptococcal diseases, the factors in staphylococcal infections, and bacterial genetics.

The National League for Nursing received a \$23,000, six-month grant, the thirteenth successive such award, from the National Foundation-March of Dimes. It will be used to continue (continued on page 317)

Illinois Medical Journal

Panalba* product information

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Usual Adult Dosage: 1 or 2 capsules three or four times a day.

Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless infections is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U.S. PAT. OFF. COPYRIGHT 1961, THE UPJOHN COMPANY

DECEMBER, 1961

STATE News (continued from page 312)

the league's nationwide student recruitment program for both professional and practical nursing careers.

In a recent three-year period over-all enrollment in various nursing education programs rose by more than 5,000, including those applying for bachelor's degrees, nursing diplomas, and two-year associate degrees.

Honors Bestowed

Dr. John J. Madden, professor and chairman of neurology and psychiatry at Loyola University's Stritch School of Medicine, was presented an honorary degree of doctor of science by the university on February 7. The honor came for his contributions in the field of medicine and especially psychiatry. A Loyola faculty member since 1938 and a 1928 graduate of the medical school, he is chairman of Loretto Hospital's neurology and psychiatry department and chairs both Gov. Kerner's Illinois Psychiatric Advisory Council and the Dean's Subcommittee for Psychiatry at Hines VA Hospital.

Dr. Angelo P. Creticos of Chicago has received the Decree of Silver Cross of the Order of George from the Government of Greece.

The Night Watch

Seventy-five physicians in Skokie have responded to Mayor Myron Griesdorf's request for an emergency night service. The village is the first suburb to institute this system—whereby a citizen in distress can contact a physician at once by dialing CEntral 6-4200.

NIH Animal Care Research

The Division of Research Grants of the National Institutes of Health has issued a contract to the Animal Care Panel at Argonne to "determine and establish professional standards for laboratory animal care and facilities."

An ACP investigating committee has been formed and is scheduled for a series of work sessions to review available information and compile a brochure on standards for laboratory animal care and facilities. The brochure is scheduled for publication later this year.

General

Health Department Personnel Changes

Eugene L. Wittenborn, Springfield, was appointed to the newly created post of assistant to the director of the Illinois Department of Public Health, effective March 1. Mr. Wittenborn, who has served in the department since 1937, will also be chief of the Division of General Administration.

Dr. Roger F. Sondag, who had been acting deputy director, relinquished this post to assume full-time duties as chief of the Division of Hospitals and Chronic Illness. He had headed this on a part-time basis since last fall.

1961 Licensure of Homes for the Aged

During 1961 the Illinois Department of Public Health's geriatrics program covered the licensing of the following nursing homes, sheltered care homes, and homes for the aged:

Original licenses (for newly constructed homes or existing ones with changes in owner-

ship) went to 56 nursing homes; 415 were issued license renewals.

Thirty-seven sheltered care homes were given original licenses and 212 granted renewals.

Twenty-two original and 64 renewal certificates were awarded homes for the aged operating not-for-profit and providing one or more of these services — sheltered care, nursing care, and special geriatric facilities.

Migrant Labor Camp Law Now in Effect

The first Migrant Labor Camp Law in the state is now in effect and will govern the almost 500 Illinois labor camps housing 15,000 people annually. It will be administered by the State Department of Public Health Division of Sanitary Engineering.

Under its jurisdiction will be any person hiring six or more seasonal or temporary migrant workers with living quarters of any kind on the premises.

Applications for a license must be on forms furnished by the department and be made at least 30 days and not more than 90 days prior

Resthaven

Therapeutic

Diagnostic

Custodial

Modern medical aid combined with home like surroundings for the treatment of acute and chronic mental and emotional illnesses, agitated senility, and alcoholics.

Superior nursing care.

35 minutes from downtown Chicago

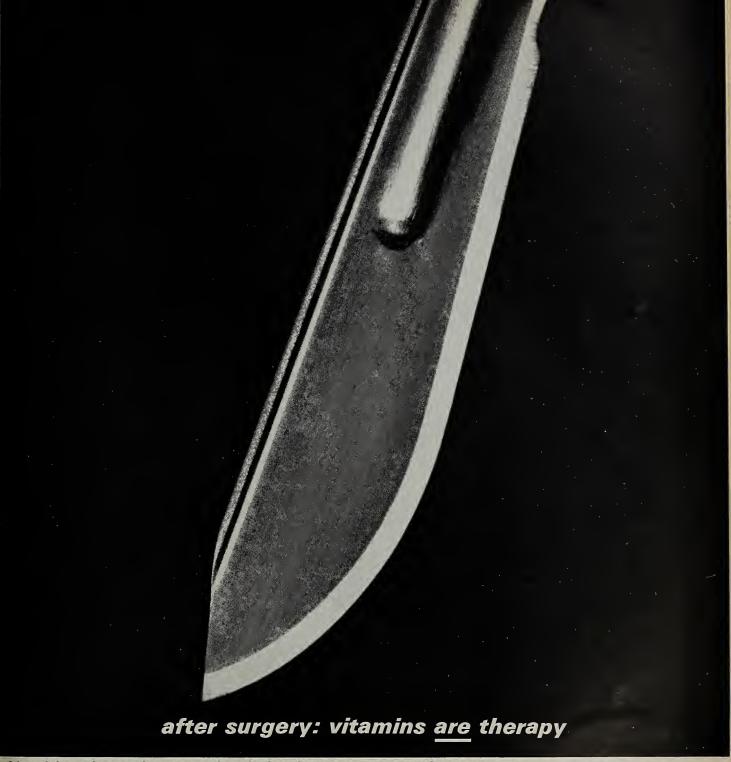
For Information

RESTHAVEN SANITARIUM

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Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery. Packaged in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B, (Thiamine Mononitrate)	10 mg.
Vitamin B ₂ (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B ₆ (Pyridoxine HCI)	2 mg.
Vitamin B ₁₂ Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle





to the date on which occupancy of the camps is to begin. The primary purpose of the law is protection of health.

Fluoridated Water Benefits Six Million

In 1961 six additional Illinois communities added fluorides to their water supply, making a total of 129 communities with this advantage. This number, combined with the 140 communities having a water supply already containing sufficient natural fluorides, brings the total persons receiving this dental benefit in the state to almost six million.

TB Institute Releases 1961 Booklet

The 1961 "Diagnostic Standards and Classification of Tuberculosis" from the Tuberculosis Institute of Chicago and Cook County is meeting with an enthusiastic response from physicians in this area. There were 882 immediate requests, and more are coming in at the rate of 250 a day.

The booklet has been completely rewritten since its 1955 edition to provide up-to-date techniques and classifications, and to conform with the rapidly changing problems of TB control.

Physicians throughout the country may obtain a free copy through their local TB associations.

Admitted to Supreme Court Practice

Walter L. Oblinger, director of legislative activities and general counsel for the Illinois State Medical Society, was admitted to practice before the U.S. Supreme Court in Washington in January.

Mr. Oblinger, who lives in Springfield, is a member of the Illinois State Bar Association Committee on the Unauthorized Practice of Law and has written many articles on medicallegal matters for the Illinois Medical Journal.

State to Attack Heart Disease

Dr. William T. Langston, U.S. Public Health Service field representative on heart disease and chronic illness, has been assigned to the Illinois Department of Public Health at the request of Dr. Franklin D. Yoder, director.

Dr. Langston will assist in promotion and evaluation of the rheumatic fever prophylaxis program, home care services for heart patients, the Chicago heart sounds screening and multiphasic screening projects, and other programs for preventive measures in diseases responsible for long-term illnesses. He will soon conduct a county-by-county survey into cardiac diseases in the effort to correlate causative factors.

Mental Health Council Appointees

Four physicians have been appointed to the 17-member Advisory Council on Family and Children's Services of the Illinois Department of Mental Health. They are Drs. William Freeburg, Carbondale; James Graham, Springfield; Gustave Lage, Oak Park, and William Schnute, Chicago.

The council will advise the department with respect to services to and programs for children and their families:

Illinois Yearly Disease Rates Compared

Several releases from the State Department of Public Health have indicated some of the increases and decreases in the number of reported cases of certain diseases. They are summarized in the following table:

Increases	1961		1960	
Rabies	163		84	
Infectious				
Hepatitis	2,605		1,697	(61 deaths)
Diphtheria	10		9	
Typhoid	28		19	
Rheumatic				
Fever	1,849		1,598	
Gonorrhea	26,575		22,608	
	(23,264	Chicago;	(19,525	Chicago;
	3,311	downstate)	3,083	downstate)
Syphilis	8,754		over 2,0	00 cases
	(7,169	Chicago;	below 1	961
	1,585	downstate)		

Decreases	1961	1960
Poliomyelitis	29	145
Encephalitis	151	167
Brucellosis (undulant fever)	59	74
Meningitis (all types)	737	749

There were no cases of smallpox in 1961 for the 14th successive year.



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine.

It's good nutrition to encourage people to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus products.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, the deliciousness of Florida orange juice will assure you that they'll want to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

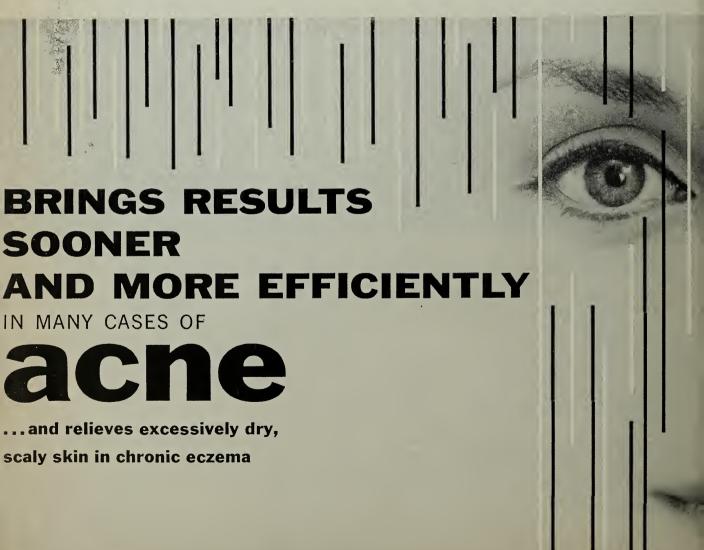
Deaths

James W. Barrow*, retired, Carbondale, a graduate of the Washington University School of Medicine in 1909, died December 20, aged 87. He was past president, vice president, and secretary of the Jackson County Medical Society. Carbondale Clinic and Doctors Hospital were built and created around his practice; he also helped form and operate the Amy Lewis Hospital, now the Holden Hospital. A new wing of this hospital was dedicated to Dr. Barrow in 1954, and that year he retired after practicing in Carbondale 44 years. In World War I he served with the U.S. Army Medical Corps.

Frank W. Blatchford, Jr.*, Winnetka, a graduate of Rush Medical College in 1935, died December 27, aged 53. He was certified in internal medicine and was an attending physician at Evanston Hospital and a fellow of the American College of Physicians. In World War II he was a Navy physician.

ERNEST A. BREDLAU*, Oak Park, a graduate of the University of Illinois College of Medicine in 1913, died September 14, aged 71. He was an emeritus member of the Illinois State Medical Society. An attending surgeon at Lutheran Deaconess Hospital, Chicago, he was certified by the American Board of Otolaryngology in 1928 and was a member of the American Academy of Ophthalmology and Otolaryngology.

Harry J. Dooley*, Oak Park, a graduate of Northwestern University Medical School in 1911, died January 1, aged 73. Certified in urology in 1941, he was an associate professor of urology at Stritch School Medicine of Loyola University and an Oak Park physician 35 years. Dr. Dooley also was attending urologist at St. Anne's, West Suburban, Oak Park, St. Anthony de Padua, Chicago State, Elmhurst Memorial, Westlake, and Municipal TB hospitals. A former councilor of the Illinois State Medical Society, he was an emeritus member of the Society and he belonged to its 50-Year Club. His fellowships included the American College



of Surgeons, the World Medical Association, and the International College of Surgeons.

EDMUND E. KIETZER, retired, Chicago, a graduate of Bennett Medical College in 1915, died January 1, aged 75. He had retired from practice in 1954. He served for 37 years as a Chicago Board of Health quarantine officer, and was a former president of the board of commissioners of the old Albany Park District, and a director and former treasurer of Concordia Mutual Life Association.

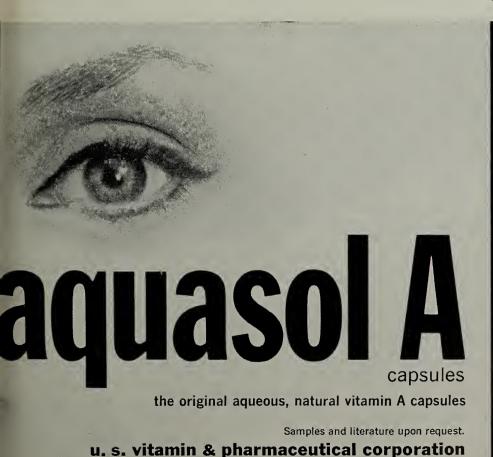
HAROLD T. LITTLE*, Aledo, a graduate of Northwestern University Medical School in 1937, died December 21, aged 51. In 1939 he was commissioned in the Medical Corps of the Regular Army and in 1941 was assigned to duty in the Panama Canal Zone. In 1940 he established a base hospital at Camp Livingston, Alexandria, La., and another at DeWitt General Hospital, Auburn, Cal., in 1943. From 1944-46 he was Surgeon General of the U.S. Army Department of Alaska and received the Legion of Merit for his work there. For the last three

years he had been coroner's physician for Mercer County and also was a member of the Aledo Board of Health.

Affiliations included a fellowship in the American College of Surgeons and memberships in the American Society of Abdominal Surgeons and the American Legion. A shetland pony fancier, he was a member and officer of several related organizations.

Hugh N. Mackechnie*, retired, Chicago, a graduate of the Medical Faculty of Trinity University, Toronto, in 1901, died January 17, aged 87. He studied also in Edinburgh, Glasgow, and London. He was a former head of the surgery department at Stritch School of Medicine of Loyola University and a past president of the Chicago Medical Society. He served on the society's council and board of trustees for 31 years and in his twenty-eighth year received a plaque for the longest tenure with the council. Since 1948 he was an emeritus member of the Illinois State Medical Society and be-

(continued on page 326)



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Editorial; JAMA. 178: 1158,

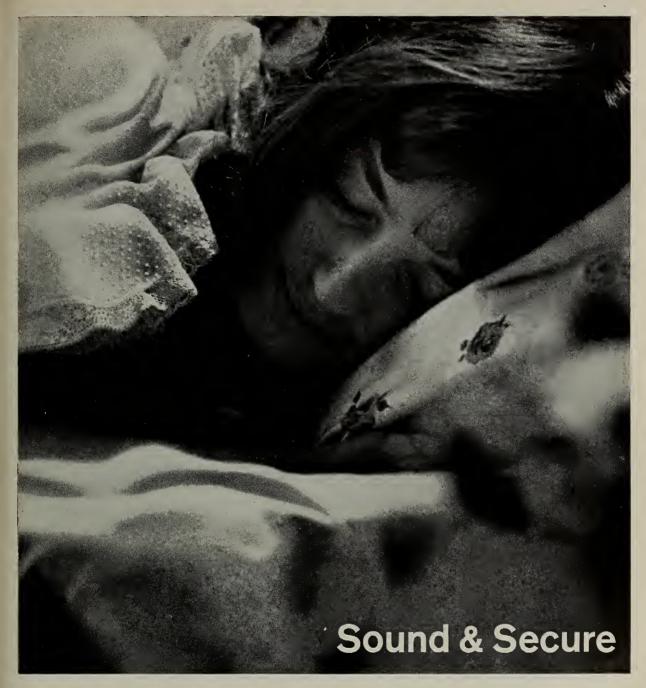
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REFERENCES: 1. Blumberg, N., Everts, E.A., and Goracci, A.F.: Pennsylvania M.J. 59:808 (July) 1956. 2. Matlin, E.: M. Times 84:68 (Jan.) 1956. 3. Hodge, J., Sokoloff, M., and Franco, F.: Am. Pract. & Digest Treat. 10:473 (March) 1959. 4. Burros, H. M., and Borromeo, V. H. J.: J. Urol. 76:456 (Oct.) 1956. 5. Lane, R. A.: New York J. Med. 55:2343 (Aug. 15) 1955. 6. Weston, D.T.: Journal-Lancet 76:7 (Jan.) 1956.

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(continued from page 323) longed to the 50-Year Club.

In 1951 he became assistant chief surgeon at Illinois Central Hospital, and on retirement in 1960 was named consulting surgeon. He had been attending surgeon or consultant to the Illinois Central Railroad, Lakeside, Frances Willard, South Shore, Illinois Masonic, Post-Graduate, and Schriner's hospitals, and for the Veterans Administration.

Dr. MacKechnie was a fellow of the American College of Surgeons and a member of the Institute of Medicine of Chicago, the Chicago Pathologic Society, and the Association of American Railway Surgeons.

Roe J. Maier*, Chicago, a graduate of Ohio State University College of Medicine in 1921, died December 22, aged 67. Certified, he was attending radiologist at Christ Community, Oak Lawn, and Evangelical hospitals and consulting radiologist at St. Bernard's Hospital. He belonged to the Radiological Society of North America, the American Roentgen-Ray Society, was a fellow of the American College of Radiology, and a past president of the Chicago Roentgen Society.

JOHN K. McQuarrie*, retired, Palos Park, a graduate of the University of Toronto Faculty of Medicine, Ontario, in 1895, died January 11, aged 89. Before his retirement in 1955 he had practiced 60 years and had been the oldest staff member at Englewood Hospital. An emeritus member of the ISMS, he also belonged to its 50-Year Club.

WILLIAM A. MICHAEL*, retired, Peoria, a graduate of the Washington University School of Medicine in 1921, died December 27, aged

65. He was past head of the department of obstetrics and gynecology at St. Francis Hospital, past president of the board and consultant to the Crittenton Home, and a member of the Peoria Board of Health. He was certified in 1936 and belonged to the American College of Obstetricians and Gynecologists, the Central Society of Obstetricians and Gynecologists, and the American Businessmen's Club.

Salvatore F. Mirabella*, retired, Chicago, a graduate of the University of Illinois College of Medicine in 1907, died January 8, aged 77. He had been a staff surgeon at Mother Cabrini Memorial Hospital nearly 50 years before retiring five years ago. He was a member of the ISMS 50-Year Club.

David Nusbaum*, Chicago, a graduate of the University of Illinois College of Medicine and Surgery, Chicago, in 1904, died January 2, aged 79. He had practiced in Freeport over 50 years and had operated Emergency Hospital there for several years. He was a member of the 50-Year Club of the ISMS and an emeritus member of the Society.

Felix A. Tornabene*, Aurora, a graduate of Loyola University School of Medicine in 1937, died January 15, aged 49. Formerly health director for the northeast region of Illinois, he was Will County Public Health Director since 1958.

He was certified in preventive medicine and held fellowships in the American College of Preventive Medicine, the American Public Health Association, and the Middle States Public Health Association.

^{*}Indicates member of Illinois State Medical Society.



Action of Special Meeting, House of Delegates

Sunday, March 18, 1962



We are reprinting a copy of the resolution presented by the Reference Committee on Sunday, March 18, 1962 which endorsed the <u>Blue Shield National Senior Citizen Program</u>, the subject of the call for the special meeting. Other detailed information should be secured from the delegate or delegates from your county medical society in attendance at the sessions.

This resolution was passed unchanged by the House of Delegates. Dissenting votes were registered from five delegates with a total of 122 members of the House seated at the final session on Sunday morning.

REPORT OF REFERENCE COMMITTEE #1

Mr. Chairman and Members of the House of Delegates:

Your Reference Committee has considered carefully the communications and the remarks of all delegates who spoke before the committee in open session. We reviewed in detail in executive session, the several resolutions presented to the House of Delegates. Although these resolutions varied somewhat in form, basically they expressed approval of and support for the Blue Shield National Senior Citizen Program and its objective of improved voluntary prepaid health service for our senior citizens.

Therefore we offer the following composite resolution which incorporates the essential features of these resolutions and the consensus of the delegates expressed at the Reference Committee hearing:

WHEREAS, a uniform program for the prepayment of physician services through joint underwriting by 68 Blue Shield plans across the nation has been devised and now appears feasible when implemented with state medical society approval, and

WHEREAS, such an endeavor will enable persons 65 years of age and over to provide adequate coverage for themselves at a cost which is within their means, without government interference in the practice of medicine, and

WHEREAS, the Blue Shield National Senior Citizen Program is in agreement with the intent and conditions of resolutions passed by the House of Delegates of the American Medical Association in December 1958 and the House of Delegates of the Illinois State Medical Society in May 1959 and has been approved in principle February 3, 1962, by the Board of Trustees of the American Medical Association and recommended by the Council of the Illinois State Medical Society February 11, 1962, and

WHEREAS, this proposed implementation of the Blue Shield National Senior Citizen Program through Illinois Medical Service (Chicago Blue Shield) conforms to the principles of the existing plan under the Illinois Medical Service series 65 certificate, which has been accepted by a large percentage of participating physicians,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Illinois State Medical Society approves the Blue Shield National Senior Citizen Program, including the income limits for paid in full benefits and the recommended schedule of allowances, and

BE IT FURTHER RESOLVED, that the Blue Shield National Senior Citizen Program be periodically reappraised by the Illinois State Medical Society, and

BE IT FURTHER RESOLVED, that Officers, the Council and the House of Delegates institute a program urging the support and participation of all physicians in Illinois in this Blue Shield National Senior Citizen Program, and

BE IT FINALLY RESOLVED that the House of Delegates of the Illinois State Medical Society concurs with the A.M.A. statement that this is a plan to provide medical fare for the aged, and of encouragement for other types of voluntary prepayment organizations to develop and implement similar programs.

Respectfully submitted, Eugene T. McEnery, M.D., Chairman William H. Whiting, M.D. H. Kenneth Scatliff, M.D. Harold C. Lueth, M.D. William Schowengerdt, M.D.

Abstract of Council Actions

Meeting of March 18, 1962

PASS RESOLUTIONS DEALING WITH DRUG PATENTS AND ADVERTISEMENTS
Two resolutions submitted by Dr. Jacob E. Reisch, Springfield, chairman of the Journal Committee, were approved:

(1) That the ISMS, acting in the best interest of the medical profession, oppose all provisions of the Kefauver-Celler Bill in Congress (SB 1552 and HR 6245), dealing with drug patents, and to institute and actively support measures conducive to stimulating pharmaceutical research and development

for the purpose of medical progress; and

(2) That while agreeing with the basic concepts of full disclosure as set forth in the Dingell Bill (HR 6471), nonetheless the ISMS opposes the requirements this bill imposes relative to medical journal advertising. This resolution also provides that the ISMS vigorously support measures which would resolve the problem of full disclosure in medical journal advertisements in a "workable and satisfactory manner." One such pending measure would require the following statement in advertisements: "Before prescribing be sure to consult the manufacturer's literature for information about possible side effects and contraindications."

Dr. John J. Procknow, Chicago, chairman of the Liaison Committee to the Illinois Hospital Association, reported that 227 hospitals in Illinois are accredited and that 35 others are eligible. He recommended that the latter be urged to seek accreditation. Council concurred.

APPROVE PRESENTATION OF STATEMENT ON NURSING TO HOUSE OF DELEGATES Dr. Ted LeBoy, Chicago, chairman of the Committee on Nursing, asked approval of the submission of a statement to the House of Delegates endorsing "in principle" nursing education in junior colleges wherever practical as an added facility. The statement also provides that the Society have a guiding hand in changes in the law governing the curriculum. Council approved the presentation.

IMPARTIAL MEDICAL TESTIMONY PROGRAM EXPANDING DOWNSTATE

Dr. Samuel A. Levinson, Chicago, chairman of the Committee on Impartial Medical Testimony, reported that the program was taking on increased importance downstate. Money to cover a part of the cost has been received from the Ford Foundation. Contributions from other sources are anticipated. These are expected to finance the project until such time as tax funds become available.

Upon the recommendation of the committee, Dr. Edmund F. Foley, professor of medicine at the University of Illinois College of Medicine, was appointed as a consultant and medical advisor of the committee to succeed Dr. LeRoy

Sloan, deceased.

NEW COMMITTEE APPOINTMENTS AND CHANGES ARE APPROVED

On recommendation of the Executive Committee, the Council approved the

following appointments:

(1) Dr. Harry Phillips, East. St. Louis, chairman of the Committee on Mental Health to succeed Dr. F. Garm Norbury, Jacksonville, who resigned because of ill health; (2) a committee on AMA-Educational Research Foundation composed of Drs. Arkell M. Vaughn, Chicago, chairman; George F. Lull and George Turner, Chicago; Edwin S. Hamilton, Kankakee; Joseph Mallory, Mattoon; (3) Dr. George Turner, Chicago, to replace Dr. Andrew J. Brislen as ISMS representative on the Health Scholarship Program of the National Foundation; (4) Dr. H. Close Hesseltine, Chicago, chairman of a committee to meet with the Osteopathic Society, the other members of the committee to be selected with Dr. Hesseltine's co-operation and suggestions.



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I SEE IT FROM '360'

By Robert L. Richards Executive Administrator

Dexter First Executive Director of Aesculapian Association

A few months ago I wrote in this column that the Will-Grundy County Medical Society was about to begin a new experiment in community service. Here is the latest information on their efforts which have culminated in the employment of Mr. Harry Dexter, effective April 1,

Harry Dexter

1962, as the first Executive Director of the Aesculapian Association of Will-Grundy County. I first met Harry in 1958 when, as a field representative for Kiwanis International, he helped me build a new Kiwanis Club in Mechanicsburg, Pennsylvania. In four short days he accomplished his mission and went on to build many

more clubs. During the past eighteen months he has served as Executive Secretary of the Illinois Medical Political Action Committee. It is now my privilege to welcome Harry to the ranks of other full and part-time county medical society executives.

The Aesculapian Association of Will-Grundy County has evolved from an informal, loosely-knit organization of dentists, doctors, and druggists into a progressive and stimulating one coordinating the business administration and programming of the county dental, medical and pharmaceutical societies into one central headquarters.

The association's objectives are: (1) to produce a complete administrative service to the members of each participating society, and (2) to provide a program of cooperative and effective community service to the public.

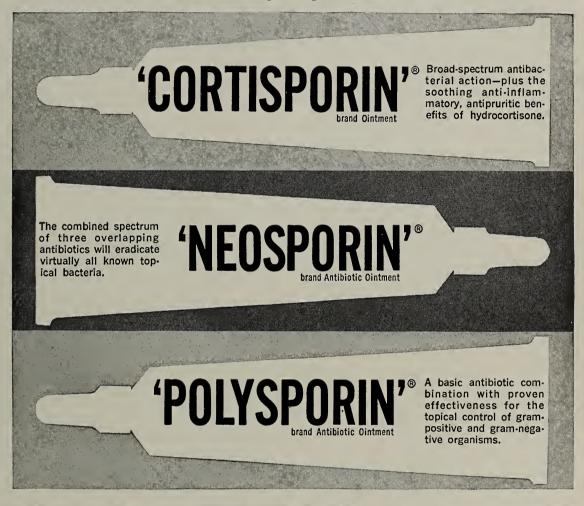
This demonstration of the professions working together will provide better services to the people and will be of immeasurable value to the communities as well as a service to the professions themselves.

Individual society meetings will be arranged and programmed as well as meetings of the Aesculapian Association. A newsletter for members will be published and a constant liaison maintained with the respective state and national organizations of each society. A unique 24-hour answering service with one telephone number producing any necessary emergency services of dentistry, medicine, and pharmacy around the clock, seven days a week, will be instituted.

Other programs of community cooperation include a speakers' bureau and a film distribution center. "Career days" and various emphasis programs directed toward specific health matters will have the complete cooperation and assistance of the association, as will all programs for community progress. Close liaison will be established with the proper organizations and agencies throughout the counties, and a friendly, yet professional "open door" program for counselling with the public on grievances will be maintained.

The association will be governed by a nineman board of directors, three from each society, plus the presidents of the societies who are exofficio members. Term of office on the board is three years. The present board is established with three, two, and one year terms. After this year, each society will select one member for a full term to replace those whose terms have expired in each year. Officers will be elected by the Board of Directors, and each office will be rotated annually among the three professions. The association has been incorporated under the laws of the State of Illinois.

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Medicine, Civic Leaders Honor Dr. Hamilton

Business, professional and civic leaders and citizens of Kankakee joined with county, state and American medicine in observing March 14 as "Dr. Edwin S. Hamilton Day."

A program covering the afternoon and evening was presented in the Hotel Kankakee by the sponsoring organization, the Kankakee County Medical Society, assisted by its Woman's Auxiliary. The evening dinner drew a capacity attendance of 180.

Many of the speakers extolled the contributions of Dr. Hamilton to the medical profession at the county, state, national and world levels. Dr. George F. Lull of Chicago, president elect of the Illinois State Medical Society, gave a biographical account which went back to World War I when he and Dr. Hamilton were in the same convoy to France.

Among the other state society figures who participated were Dr. Edward A. Piszczek of Chicago, chairman of the Council; Dr. Walter C. Bornemeier, presiding officer of the House of Delegates; Drs. J. Mather Pfeiffenberger of Alton, James H. Hutton of Chicago, Leo P. A. Sweeney of Chicago, and H. Close Hesseltine of Chicago, all past presidents; Dr. Eugene T. McEnery of Chicago, second vice president; and Dr. Caesar Portes of Chicago, member of the Council.

Dr. Gunnar Gundersen of LaCrosse, Wis., a past president of the AMA, who served on the AMA Board of Trustees with Dr. Hamilton, attended to pay tribute. Mr. Thomas A. Hendricks of Chicago, assistant to the executive vice president of the AMA, carried the greetings of Dr. Leonard W. Larson, AMA president. Dr. J. J. Moore of Chicago, long-time treasurer of the AMA, praised the accomplishments of the honored guest.

The love and respect of Dr. Hamilton's colleagues in Kankakee County were voiced by Dr. Leonard B. Shpiner of Kankakee, president of the Kankakee County Medical Society, and Dr. Sheldon W. Reagan of Aroma Park, secretary. A message from the Chicago Medical Society was carried by Dr. Casper M. Epsteen of

Chicago, president elect. Dr. Granville A. Bennett of Chicago, dean of the University of Illinois College of Medicine, told of Dr. Hamilton's contribution to medical education and practice.

Gov. Otto Kerner sent his congratulations through Lt. Gov. Samuel H. Shapiro and cited the "exemplary contributions of Dr. Hamilton to community and medicine."

Mayor Ray H. Nourie, who had proclaimed "Dr. Edwin S. Hamilton Day," said Kankakee "is proud to have such a man in our community, not only as a doctor but as a businessman and good neighbor."

The dinner speaker, Lawrence H. Hapgood of Chicago, assistant secretary for program development, Kiwanis International, called the honored guest "a believer in the dignity of the individual." Mr. Hapgood stressed that a challenge of citizenship is participation in community affairs, as exemplified by Dr. Hamilton. Mrs. Hamilton shared the limelight with her husband for being a devoted helpmate to him through the years, making it possible for him to devote so much time to organized medicine.

The committee in charge included the officers of the Kankakee County Medical Society and the following members: Drs. Herbert P. Swartz, Charles Allison, Delbert K. Judd, John Burnett, and Henry A. Hartman.

The honors bestowed upon Dr. Hamilton are richly deserved. He has been a consistent and vocal proponent of the freedom of medicine throughout his 49 years of medical practice. He is one of the founding members of the World Medical Association and a member of its board of trustees. He has traveled internationally for the WMA and AMA, is a former chairman of the AMA Board of Trustees, and has served on the Illinois State Medical Society Council for 27 years, the longest term of any member.

In Kankakee, he is vice president of the City National Bank, president of the Kankakee County Title and Trust Company, a director of the Chamber of Commerce, a director of the Hotel Kankakee, and a past president of the Kiwanis Club.

Dr. Hamilton Day Highlights



TOP LEFT (Left to right). Dr. Gunnar Gundersen, past president of AMA; Dr. J. Mather Pfeiffenberger, oldest living past president of ISMS; Dr. Hamilton; Dr. Leonard B. Shpiner, president of Kankakee County Medical Society.

CENTER LEFT (Left to right). Mrs. Harlan English, president of Woman's Auxiliary to AMA; Dr. Hamilton; Mrs. Richard E. Westland, president of Woman's Auxiliary to ISMS.

BOTTOM LEFT (Left to right). Dr. Charles Allison, master of ceremonies at dinner; Dr. Henry A. Hartman, presiding officer at afternoon session; Dr. Sheldon W. Reagan, secretary of Kankakee County Medical Society; Dr. Hamilton; Dr. Leonard B. Shpiner, president of Kankakee County Medical Society.

TOP RIGHT (Left to right). Dr. Hamilton; Dr. H. Close Hesseltine, immediate past president of ISMS; Dr. Granville A. Bennett, dean, University of Illinois College of Medicine; Dr. George F. Lull, president-elect of ISMS.

CENTER RIGHT (Left to right). Dr. Charles Allison, master of ceremonies; Mr. Lawrence H. Hapgood, assistant secretary for program development, Kiwanis International, and dinner speaker; Dr. Hamilton.

BOTTOM RIGHT (Left to right). Dr. Hamilton and his family: Mrs. Hamilton, daughter Helen Jane, and son Edwin Clark.

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References: (1) Moss, J. M.; Schreiner, G. E., and Sweeney, V.: M. Times 89:12 (Jan.) 1961. (2) El Mahallawy, M., and Sabour, M. S.: J.A.M.A. 173:1783 (Aug. 20) 1960.

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The ILLINOIS Medical Journal

Official Journal of the Illinois State

Medical Society

April, 1962

Volume 121, No. 4

Anemia and Other Hematologic Abnormalities As Manifestations of Malignant Disease

Albert B. Hagedorn, M.D., Rochester, Minn.

Anemia is not Usual early in the pathogenesis of malignant diseases as a whole. Malignancy, per se, does not necessarily cause anemia even in some far advanced cases. When anemia does accompany a malignant process, it is most often a normochromic normocytic anemia. In addition, other hematologic changes such as hypochromic microcytic anemia, macrocytic anemia, myelophthisic process, or hemolytic anemia may be present due to malignant disease.

The Mechanism

The mechanism whereby malignant disease results in normochromic normocytic anemia is not entirely clear in spite of a voluminous literature on the subject. Most of the current information comes from radioisotopic studies. In many of these an occult hemolytic process manifested by a shortened erythrocyte survival

time is reported. Some cases show evidence of a humoral factor in the plasma affecting the erythrocytes directly and, in some instances, leading to premature aging of the erythrocytes; others show evidence of decreased or suppressed erythrogenesis as evidenced by decreased plasma-iron turnover rates. Evidence to indicate combined factors also has been published.

It would appear reasonable to state that decreased survival, increased destruction, or suppressed production of erythrocytes due to various factors plays a part individually or in combination to produce the normochromic normocytic anemia of malignant disease. At the Mayo Clinic for example, laboratory studies with radioiron (Fe⁵⁹) and radiochromium (Cr⁵¹) show that the anemia of some malignant disease results from a combination of diminished erythropoiesis and an increased destruction of red blood cells. The anemia of chronic myelogenous leukemia is due primarily to diminished erythropoiesis; however, in some cases of chronic myelogenous leukemia a factor of hemodilution may give a relative anemia.

The hypochromic or hypochromic-microcytic anemia that occurs in malignant disease is readily explainable. Invariably it results from loss of blood, usually occult, that goes on unnoticed. In addition, blood loss may occur

From the Section of Medicine, Mayo Clinic and Foundation. Read before the Sections on Cardiovascular Disease and Medicine at the 121st Annual Meeting of the Illinois State Medical Society, Chicago, May 16, 1961

intratumorally or intra-abdominally, further complicating the problem. Hypochromic anemia should alert the physician to a bleeding lesion. Most frequently this involves the gastrointestinal tract. It is important to consider that the patient may have had a pre-existing iron deficiency. This may be true especially of women. Under such circumstances the anemia may not be related to the malignant process and appropriate iron medication may be of great palliative benefit.

Macrocytic anemias sometimes associated with malignant disease probably relate to interference with absorption or utilization of vitamin B₁₂ or folic acid. This can occur in the chronically ill patient with a malignant disease owing to failure to secrete intrinsic factor, e.g., in carcinoma of the stomach or in a primary or metastatic malignant lesion involving the liver. In addition, some aberration in the normal metabolism of the vitamins in malignant disease may lead to macrocytosis. This latter process is illustrated most dramatically by the few patients having acute leukemia treated with folic acid antagonists in whom megaloblastic bone marrow and consequent macrocytosis have occurred during induced remission.

Myelophthisic anemia can result from involvement of bone marrow by either primary or metastatic malignant disease. We have seen primary Hodgkin's and reticulum cell sarcomas involving only the bone marrow. Invariably anemia was prominent. In rare instances the bone marrow may become fibrotic or sclerotic in a malignant process rather than being merely invaded by neoplastic cells. This is most frequently noted in cases of carcinoma of the breast with splenomegaly and myeloid metaplasia.

Finally, frank hemolytic anemia may occur. This has been seen rarely with carcinomatous disease, but it is not so rare with lymphomatous or leukemic disease. In the primary lymphomas, hemolytic anemia occurs oftenest in Hodgkin's disease and chronic lymphocytic leukemia:

It also seems pertinent to note that a paradox can occur in malignant disease: Polycythemia rather than anemia may be present. This is seen oftenest in renal carcinoma or hypernephroma. The mechanism presumably is

similar to that of polycythemia in benign conditions such as uterine fibromyomas, hydronephrosis, and benign cysts of the kidney.

When anemia is present, it is always necessary to find the cause. Anemia is not a disease; it is a sign or symptom of some primary process. Therefore, it is of paramount importance that, whenever anemia is present, the physician make an active effort to seek the cause and remove it if possible.

Classification of Anemia

The laboratory affords an opportunity for accurate classification of anemia. A well-prepared, well-stained blood smear is of greatest importance in the tests or examinations of the blood. Most often this simple procedure, which can be carried out by any physician in possession of a microscope, affords an accurate classification of the type of anemia. In addition, much other information can be obtained.

Rouleaux. The presence of rouleaux is worth noting. In a review of 414 instances of excessive rouleaux formation made in the clinic laboratory, 93 per cent of the patients had significant organic disease, 136 per cent of these a neoplasm. The simultaneous occurrence of appreciable myeloid immaturity and excessive rouleaux formation may be evidence of an underlying neoplasm. This combination contradicts the probability of chronic myelogenous leukemia, although the differential diagnosis may indicate its consideration.

Leukoerythroblastosis. When normoblasts occur in the blood in conjunction with myeloid immaturity or leukocytosis, the presence of a neoplasm should be considered, especially when rouleaux formation is present. Obviously normoblastosis and myeloid immaturity can occur in frank hemolytic disease or myeloid metaplasia of various causes, and these considerations should be excluded. In a patient with known malignant disease a leukoerythroblastic blood picture is excellent presumptive evidence of metastasis. Even the presence of a few normoblasts in the peripheral blood under such circumstances should indicate metastatic disease.

Leukemoid Findings. An increased leukocyte count with scattered myeloid immaturity without normoblastosis not infrequently accompanies malignant disease and, again, frequently although not invariably, is associated with metastasis. Leukocytosis is unusual in myelophthisic anemia associated with metastasis; usually there is leukopenia and often an accompanying thrombocytopenia.

Eosinophilia. Eosinophilia, occasionally of high degree, may be found in association with malignant disease. Isaacson and Rapaport² have reported on 34 cases of malignant tumor with eosinophilia of more than 10 per cent. Stickney and Heck³ reviewed 418 cases of eosinophilia encountered at the Mayo Clinic in which 10.3 per cent were associated with malignant tumor. Grewe and Schlitter⁴ reviewed 800 cases of tumor and noted eosinophilia in 197. Hanlon⁵ reported a case of carcinoma of the rectum with eosinophilia of 37 per cent. An advanced leukemoid reaction and increased rouleaux formation also were present in his case.

Toxic Changes. Severely toxic changes in the polymorphonuclear leukocytes in the absence of fever or other evidence of infection or septicemia should alert the physician to the possibility of neoplastic disease, especially if there is accompanying rouleaux formation, rare immaturity, or even a single normoblast. Heavy basophilic granulation, vacuolation, and irregular stranding of the chromatin are evidences of toxic changes in polymorphonuclear leukocytes.

Malignant Cells. On occasion malignant cells may be seen in the peripheral blood. At the clinic, even with special technics, this has proved to be of little clinical value in carcinomatous disease. However, the relatively high yield of malignant cells in blood aspirated at the time of operation from vessels immediately adjacent to a malignant tumor gives objective evidence for the need of care to prevent the iatrogenic spread of malignant cells.

Many satisfactory methods are available for isolating and identifying malignant cells in the peripheral blood. Basically all methods depend on separation of the leukocytes from erythrocytes and subsequent concentration of any malignant cells by centrifugation. These technics provide an interesting tool for studying the mode of spread of cancer cells as well as the effect of certain chemotherapeutic agents. The

prognostic significance of finding neoplastic cells in vessels associated with a tumor or in the peripheral blood vessels is unsettled. There seems little doubt that most tumor cells reaching the circulation are promptly destroyed or that their potential further growth is inactivated. In the future it should be possible to assess more accurately the spread of cancer cells. The technics for such studies are available already and include accurate cytologic examinations of the cells in lymph, blood, and marrow with the aid of fluorescent microscopy; cells tagged by radioisotopes; fluorescent antibodies specific for individual tumors; and quantitative assays of the number and viability of cancer cells by tissue culture. Likewise, we have not been impressed with our ability to correlate so-called leukosarcoma cells with specific lymphomatous disease. In about 10 per cent of the cases of myeloma, specific cells are apparent in the routine examination of the blood smear. In a retrospective study when the peripheral blood smear was examined along with slides of positive bone marrow, the myeloma cells were seen in 68 per cent of the peripheral blood smears.

Examination of bone marrow should not be overlooked in evaluating the anemia of malignant disease. If the anemia is secondary to a primary hematologic neoplasm, the bone marrow should be 100 per cent diagnostic. I do not believe I have ever encountered anemia due to leukemia where the bone marrow was not frankly diagnostic except in the case of chronic myelogenous leukemia where the marrow findings may not be pathognomonic, although abnormal. Likewise, malignant cells may be found in a reasonable number of patients with carcinomatous or sarcomatous disease when anemia is present. If a leukemoid reaction or normoblasts are present in the blood smear in known or suspected malignant disease, about 90 per cent of the time malignant cells will be seen in the bone marrow. In most cases of myeloma the bone marrow will be positive for myeloma cells. It is important to note, however, that fixed paraffin sections of the bone marrow are most important to have when one is looking for malignant cells. The positive yield over routine marrow smears is increased 45 per cent in metastatic malignant disease and

even 3 per cent in cases of myeloma.⁶ A practical point to remember is that when one encounters a so-called dry tap while performing a marrow aspiration, the single drop in the needle should be smeared out on a slide for staining. Malignant cells may be present in this drop; in fact, they may comprise all the material obtained. In a search for malignant cells it is desirable, if possible, to aspirate the bone marrow from a region that is tender on pressure.

Summary

Anemia of various types may be an initiating sign of a malignant disease or may develop during the course of the malignant process. The type of anemia may be a clue to the nature of the malignant disease or to its location.

Anemia associated with a leukemoid reaction or normoblastosis is usually a grave sign in most malignant processes.

When anemia occurs in a known malignant

state and normoblastosis or mycloid immaturity or both appear, metastasis almost certainly is present even though objective evidence may not be readily demonstrated.

Toxic changes in polymorphonuclear cells, particularly when associated with rouleaux formation, and eosinophilia may be clues to a malignant disease.

Fixed paraffin sections should be studied as well as bone marrow smears in a search for malignant cells in the bone marrow.

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Death and Research

Before this relatively brief address is completed, at least fifteen people will have died in the U.S.A. from cancer.

And twenty persons will have discovered that they no longer may earn a living because of a rheumatic disease. Even while I speak to you, more than 70,000 men and women of working age are at home or in hospitals, suffering from cardiovascular diseases and at the same time from loss of income. In fact, before I have completed my comments today, more than fifty men, women and children will have died from heart diseases. And maybe at least one baby will have been born with cerebral palsy.

These are the shocking and tragic facts of death, despair and sorrow. And the greatest tragedy lies in the attack of disease on the children of today, for they will be our leaders tomorrow.

But while I speak, there is hope, happiness and life, too. One by one, the scourges of the past have been vanquished by medical science. We no longer worry about bubonic plague, diphtheria, smallpox, scarlet fever, typhus and typhoid fever, which were, not long ago, major threats to our children. And we know that, one by one, the remaining scourges will be conquered — if those who make up the medical science team are permitted to pursue the research paths of tomorrow in the same fearless ways as they trod them yesterday.

We'll never overcome the inevitability of death. But the time of death, the kind of death, the ease with which death moves and the usefulness of those approaching death are largely subject only to the imagination and determination of our scientists. Austin Smith, M.D. Report to the Nation. Dec. 11, 1961.

Intraorbital and Intracranial Foreign Body

WARREN W. KREFT, M.D.*, Des Plaines JAMES J. DUFFY, M.D.†, Skokie

Many Unusual Accidents occur on the highways today, and it behooves us to examine all accident victims completely and meticulously.

Report of a Case

The patient, a 22 year old white male, was seen in the emergency room of Lutheran General Hospital, Park Ridge, the night of Sept. 15, 1960. He had been a passenger in the right front seat of an automobile struck on the right side while proceeding through an intersection.

The patient was most uncooperative, irrational, and at times violent; it was difficult to ascertain how much of his behavior was due to alcohol, concussion, etc. Examination revealed a 15 mm. superficial laceration of the left side of the nose just below the bridge and a V-shaped skin laceration 1 cm. long at the medial edge of the right eyebrow. The right upper eyelid was lacerated through and through beginning 2 mm. lateral to the superior puncta and running superolaterally for approximately 2 cm. Restraints were placed on the patient, and the skin lacerations were cleaned, infiltrated with 1% Xylocaine, and approximated with interrupted 4-0 black silk sutures. Because of poor patient cooperation only a gross examination of the right eye was possible. Its anterior chamber was filled with blood, the conjunctiva of the superior cul-de-sac was lacerated, and there was a marked indentation of the superior sclera. It was felt that there was a scleral rupture posteriorly and the prognosis for saving the eye was poor. The remainder of the physical examination was negative. Because of the patient's general condition and the possible presence of severe intracranial injury, general anesthesia was not advisable. All sutured lacerations were dressed, tetanus toxoid and penicillin given, and the patient put under restraints and observed overnight.

The next morning he was restless, uncooperative, and responded violently to stimuli. Anteroposterior and lateral skull roentgenograms (Figs. 1, 2, p. 370) revealed a large triangular object penetrating the right orbit and middle cranial fossa. It was decided to remove the foreign body from the anterior approach via the point of entry, in view of the patient's poor condition and the severe damage to the right eve. Since the foreign object was tapered, the large end posterior, greater damage would be incurred if an attempt was made to remove it through the middle cranial fossa. However, preparations for craniotomy were made in case complications occurred or the operation was not successful.

About 18 hours after admission the sutures in the right upper eyelid were removed under general anesthesia. Examination of the upper cul-de-sac revealed a jagged laceration of the bulbar conjunctiva, approximately 15 mm. from the superior limbus; the anterior chamber was filled with blood, and the eye was markedly hypotonic. Because it was impossible to palpate the foreign body behind the globe, it was decided to enucleate the eye. The conjunctiva was incised at the limbus for 360 degrees and undermined posteriorly. Approximately 10 mm.

for April, 1962

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[†]From the department of neurosurgery, Stritch School of Medicine

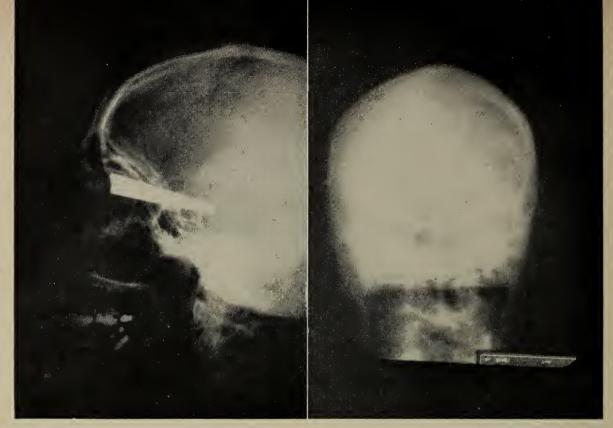


FIGURE 1. Lateral roentgenogram of the skull.

behind the limbus in the superonasal quadrant of the globe was a scleral laceration one cm. long through which extruded vitreous, choroid, retina, and lens material. The four recti muscles were isolated, whip-stitched with 4-0 chromic catgut sutures, and severed at their insertions. The optic nerve was then severed with a snare and the eye removed. Hot packs under pressure were placed in the orbit for a few minutes and then removed; since hemorrhage was slight, the orbit was palpated. A portion of the foreign body projected into the apex of the orbit and could be grasped.

A long-nosed flat pliers was applied, and with side application of hemostats the foreign body was slowly extracted without hemorrhage, evidence of cerebrospinal fluid, or shock. The posterior rent in Tenon's capsule was approximated with interrupted 4-0 chromic catgut sutures, a 16 mm. plastic sphere implanted in the orbit, and the purse-string sutures drawn up and tied. The four recti muscles were sutured over each other anteriorly, and the conjunctiva was approximated with a running 4-0 silk suture. A pressure dressing was applied and a spinal tap performed.

The metallic foreign body (Fig. 3) was a triangular, chrome plated, dye-cast piece of metal 6 cm. long, 1 cm. wide, rounded anteriorly, and irregularly fractured posteriorly.

FIGURE 2. Anteroposterior roentgenogram of skull.

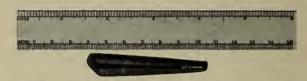


FIGURE 3. Piece of metal 6 cm. long and 1 cm. wide that had penetrated right orbit and middle cranial fossa.

Subsequent investigation revealed that it was a point of an ornamental star from the rear fender of the other car.

The spinal fluid examination was xanthochromic on gross examination, but after centrifuging was crystal clear. Cell count after centrifuge was 8.4 per cu. mm.; total protein 21.4 per 100 ml., and a Pandy's test was negative.

The patient received 900,000 units of penicillin intramuscularly on completion of surgery, and then 1,000 mg. chloramphenicol intramuscularly every eight hours. By midnight of the day of surgery the patient was rational and cooperative. Four days after surgery he was up and about and was discharged four days later.

Discussion

The anterior portion of the foreign body was rounded and did not puncture the dura. Had it been sharp, there is no doubt that the dura would have been punctured with loss of cerebrospinal fluid, infection, etc. It is amazing that no vital intracranial structure was injured. Final neurologic examination showed no evidence of damage to brain tissue. Postoperative x-rays revealed no evidence of fracture or comminution of the bones of the orbit. It is believed that the blunt anterior end of the foreign body was directed down the sloping plane of the posterior orbit into and through the superior orbital fissure, pushing intracranial structures aside or ahead of it rather than lacerating them. It was unfortunate that the eve had to be enucleated. but the damage to the globe was so severe it is doubtful that any useful vision could have been preserved. The anterior approach was the only means of removing the fragment even though extraction was a calculated risk since a vital vessel might be injured. A transfrontal craniotomy approach would have been more difficult

and traumatic and no doubt would have endangered many more vital structures.

It is recommended that the automotive industry cease using die-cast metal ornaments, trim, grills, etc., since these brittle baubles may become lethal flying fragments in an automobile accident.

Summary

A case is presented in which a young man suffered a penetrating injury to his right eye, orbit, and middle cranial fossa by a metallic foreign body. The foreign body was extracted by the anterior route after enucleating the hopelessly damaged eye. Removal of die-cast ornaments from automobiles is recommended since they may become lethal flying objects in car accidents.

How the Kefauver Show was rigged

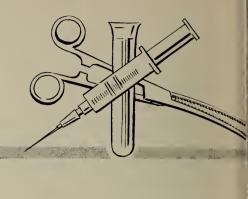
The defendant cannot raise an objection to any statement of his accusers; he has no right of cross examination, no right to call witnesses; he has no right even to know what subjects his trial will cover. He must send his writ-

ten statement to the committee 24 to 48 hours before he appears, but the committee has no obligation to let him know what questions it will ask. There are no rules of evidence. Insinuations are valid testimony. The committee calls up the real "witnesses," almost all of them carefully chosen hostile critics who seize the chance to acquaint a national audience with their views. Then there is the careful timing of adverse testimony, so that the most sensational tidbit will be released just in time for the newspapers to get the story in their early editions, and just too late for the defendant to answer. The next day his careful rebuttal is drowned out by a flood of new accusations. From an address by Mr. Francis Boyer, Chairman of the Board, Smith Kline & French Laboratories, before the 65th Annual Meeting Pennsylvania Bar Association, Philadephia, Jan. 28, 1961

Prolonged Death

Nevertheless, those animals termed easy to keep . . . are in reality . . . merely resistant and, to put it crudely, take a long time to die. The classical example of this type of animal is the Greek tortoise. Even under the inadequate treatment of the average ignorant owner, this poor beast takes three, four, or even five years until it is really, thoroughly and irrevocably dead, but, strictly speaking, it starts on the downward path from the first day of its captivity. To keep tortoises so that they grow, thrive and multiply, they must be offered conditions of life which, in a town flat, cannot be achieved. In our own climate, nobody, to my knowledge, has truly succeeded in breeding these animals. Konrad Z. Lorenz. King Solomon's Ring. Crowell Publishing Company, 1952.





Cook County Hospital

Injuries and Infections of the Hand

Moderator: John A. Boswick, Jr., M.D.

Department of Surgery, Cook County Hospital and Northwestern University Medical School

DISCUSSANTS: WILLIAM B. STROMBERG, JR., M.D.
Northwestern University Medical School, Department of Surgery
JOHN H. SCHNEEWIND, M.D.
University of Illinois College of Medicine
ALLEN F. MURPHY, M.D.
Stritch School of Medicine, Loyola University

Dr. John Boswick: To restore in some measure the hand mangled by injury or distorted from infection constitutes a unique challenge to the surgeon. The Halstedian principles of meticulous surgery are well applied to the hand; in fact, no place in surgery is their application more rewarding, nor their disregard more obvious. Reconstructive surgery, as applied to the hand should not be regarded as a subdivision or a subspecialty but more a method or technique of surgery. A surgeon treating the hand should be well versed in the principles of surgical infections, trained in fractures, peripheral nerve surgery, and in the principles of plastic surgery involved in wound closure. Many of these principles were developed here at Cook County Hospital and have been disseminated by county-trained surgeons. These principles have not changed over the years, although the emphasis upon their application has changed from time to time with different surgeons.

To discuss this problem are three men who devote a major portion of their time to surgery of the hand: Dr. William B. Stromberg, Jr., Northwestern University Medical School; Dr. John H. Schneewind of the University of Illinois College of Medicine; and Dr. Allen F. Murphy of the Stritch School of Medicine, Loyola University.

The first patient (Fig. 1) sustained repeated pin-prick trauma of the dorsum of the involved finger three or four weeks prior to being seen. Six or seven days before this photograph was taken the finger had drained daily and was painful and stiff. Dr. Murphy, will you discuss this from a diagnostic standpoint and tell us how you would treat it?

DR. ALLEN F. MURPHY: The history of pinprick trauma is extremely important. The entrance of an infective organism is followed by development of swelling, localization and accumulation of pus that drips from the wound. It must be determined whether it is still localized or has advanced sufficiently to produce a lymphangitis to the elbow or on into the nodes of the axillary area. The infective organism can be determined by culture and smear. General



FIGURE 1. Paronychia

physical examination is important to determine whether there is diabetes or lues, and so on.

Looking at this slide, I would say that the local infection has begun to spread. There is generalized swelling of the hand. The differential diagnosis is paronychia — subungual localized infection or lymphangitis due to staphylococcic or streptococcic infection. Because the wound is open, I would tend to treat this as a draining infection with lymphangitis spreading up the hand and, probably, the forearm. I would treat it with moist hot packs, the appropriate antibiotics, elevation of the part, and rest in a position of function.

Dr. Boswick: Actually, this infection is well localized. The swelling is restricted to the finger and does not extend proximal to the distal joint.

DR. MURPHY: I would treat it as paronychia and would make posterior-lateral incisions, giving adequate drainage, splint the part in the position of function, and continue the use of wet packs and antibiotics.

Dr. Boswick: Would you remove the nail?
Dr. Murphy: If there is purulent material

beneath the nail, I would remove the entire nail.

Dr. Boswick: Would you diagram on the blackboard how you would make those incisions?

Dr. Boswick: Dr. Schneewind, would you agree with this?

Dr. John Schneewind: I would try unroofing this rather than incising the finger in the midlateral aspect if there is a localized collection of pus. I am not always sure that the entire nail has to be removed. If there is some collection of pus under one portion, that portion is removed completely right down to its base.

Dr. Murphy: The type of incision is posterolateral (Fig. 2) in this direction on both sides, allowing adequate drainage of the wound. The point made about the nail is important because the base of it will be infected. If a partial excision is performed, half the distal nail will be left. A new nail will be more distorted than if a full excision is done. I believe in full excision, depending upon the accumulation of purulent

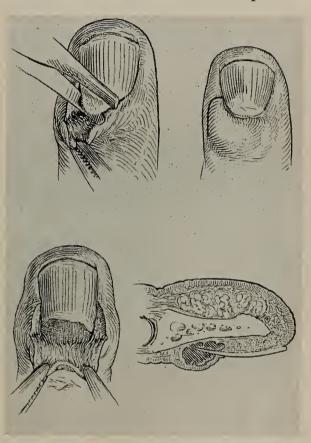


FIGURE 2. (Top and Bottom). Incision for drainage of a paronychia.

material. If it is minimal, it will not be necessary to do a full excision. If it is great, osteomyelitis into the distal phalanx may develop.

Dr. Boswick: Would you always remove the nail in every paronychia?

Dr. Murphy: I would when there is an accumulation of pus beneath the nail, and there is danger of involvement of the bone.

Dr. Boswick: Do you incise every paronychia?

Dr. Murphy: No, not if drainage is adequate

with hot moist packs.

DR. WILLIAM B. STROMBERG, JR.: I think it is correct to do that, depending upon how much nail is involved and how far distally the purulent material has gone. Frequently, I do not remove it. Not many paronychias extend far into the nail. In those not extending below the nail and showing some drainage, I push back the cuticle with a No. 11 blade to make sure there is a good drainage and then treat with moist dressings. I do not make incisions then; just sweep around underneath with a sharp knife.

Dr. Boswick: This man (Fig. 3) had an injury to his thumb while cleaning fish. The wound was said not to have bled nor to have been very painful. The photograph was taken six days after injury. The condition is localized to the distal joint. Dr. Schneedwind, would you discuss this?



FIGURE 3. Felon-distal pulp space infection.

DR. SCHNEEWIND: Dr. Murphy's remarks about general examination and taking a careful history are pertinent to every case. This, to me, has the appearance of a felon or closed space infection of the distal pulp space of the thumb. The danger in this infection is that, because the purulent material cannot escape, the resultant pressure causes ischemia which may lead to osteomyelitis and severe disability. I believe it is a felon, and the treatment of choice would be immediate incision and drainage in the lateral aspect of the thumb.

Personally, I do not use through-and-through incision or the fish-mouth incision, but a generous incision is needed because if all these septa and pockets are not given good drainage, the infection will recur in some of them. As for smear and culture, I do not wait for these, but start the patient immediately on erythromycin and chloromycetin until the sensitivity tests are returned. At the present time, these drugs seem effective against staphylococcic infections, which occur most commonly. I am concerned about inserting drains, but it is important to keep the skin edges from closing. To do this I would insert a small piece of Penrose drain for 24 hours and remove it. About 48 hours following operation, one would institute the usual treatment for infections, namely, het moist packs.

Dr. Boswick: You seem reluctant to use drains, Dr. Schneewind. How about you, Dr. Murphy?

DR. MURPHY: In a localized felon or closed space infection, I like to make lateral incisions on either side and allow through-and-through drainage. I would not hesitate to put a drain in for as long as it takes to drain it. If it did not respond I would use a fish-mouth incision, although I am reluctant to do that because of the deforming scar which follows and delay of healing.

Dr. Boswick: Dr. Murphy recommends bilateral incisions and Dr. Schneewind a lateral incision. What about you Dr. Stromberg?

Dr. Stromberg: I agree with Dr. Schneewind. I would make a lateral incision, making sure the knife sweeps all the way across to cut all fibrous septa which go down from the bone to the skin. The knife must cut all the way across. I have been taught not to drain both sides; therefore, I have not done it. Dr. Murphy states that if he did not succeed with his technique he would not persist in it. We see many felons and paronychias in the outpatient department and clinic, and also in private office practice. These wounds are frequently opened and too often the patient is told to use soaks at home. This is a big mistake, since the patient is seldom adequately informed about sterility. He will soak it but will add infection to it. If the wound needs protection and moist dressings the patient should be hospitalized or seen daily for dressing changes. Make sure you or some other responsible person sees the patient's wound daily.

Dr. Schneewind: I might add that frequently

these two infections are treated as minor conditions and really they are major. It is not uncommon for a severe felon to drain for months or even a year with sloughing of the bone ultimately.

DR. Boswick: What would you use for anesthesia?

Dr. Schneewind: I do not like to use a local anesthesia in these cases. I cannot honestly say that I have ever seen trouble resulting from a nerve block done high, but I think the ideal anesthetic is general for these conditions, unless the patient's condition requires that some compromise be made.

Dr. Boswick: What Dr. Schneewind has said about these not being slight infections should be kept in mind. There is no slight infection of the hand, nor a minor injury. They are all major.

DR. Boswick: Do you always use antibiotics in a felon, Dr. Stromberg?

DR. STROMBERG: In a felon, yes, but not always in a paronychia. We use erythromycin most frequently. If the condition is severe, I also use chloromycetin, because the two in combination are very effective. They have been used very successfully here at the County Hostal, I know.

Dr. Boswick: Do you ever treat a felon without incision?

Dr. Stromberg: Yes, if we discover it early enough.

Dr. Boswick: What would you do if it were very early and very mild?

Dr. Stromberg: Use moist dressings and antibiotics. However, if there is doubt, it should be opened.

DR. Boswick: Is the degree of pain a good guide to opening the wound by incision?

Dr. Stromberg: No.

Dr. Boswick: In draining a felon, what about the bone and tendon?

Dr. Stromberg: The tendon is quite close to the surface; to prevent infection down into the tendon sheath care must be taken to stay away from the tendon. Nevertheless, I would make the incision across the entire wound.

Dr. Boswick: This patient (Fig. 4) entered the hospital with a history of having sustained a human bite one week prior to being seen. The finger was extremely swollen with tenderness



FIGURE 4. Acute purulent tenosynovitis — secondary to a human bite — showing digital incision for drainage.

into the palm. We would like to ask Dr. Stromberg for a differential diagnosis of this infection.

Dr. Stromberg: I think a human bite infection is one of the worst that can be sustained. In this area you presume that the tendon sheath is involved. The differential diagnosis would be an acute purulent tenosynovitis or superficial infection. These are frequently misdiagnosed, but I am certain in this case. The tendon sheath of the middle two fingers extends to the distal flexion crease of the palm; opening it requires two incisions. With such incisions the entire tendon sheath should be opened along the mid-lateral line of the finger. The sheath should be opened and drained. The palm then has to be opened so that the cul-de-sac is drained. Rehabilitation of the fingers in these cases is very difficult; sequestration of the entire flexor tendon can occur and the tendon must be taken out. I would not do this unless the tendon has lost its blood supply. Other diagnostic criteria in acute purulent tenosynovitis are fusiform swelling of the involved finger, tenderness along the tendon sheath (which means involvement extends into the palm), flexion attitude of the finger and pain with extension of the finger. Subcutaneous infection beneath the fascia but not into the tendon sheath itself resembles acute tenosynovitis but does not cause tenderness in the palm. A distinction must be made between these two conditions because if there is a superficial infection and the tendon sheath is opened, a tendon sheath infection will result.

DR. Boswick: This can be a difficult diag-

nosis. If you were not sure, which of these incisions would you make first?

DR. STROMBERG: I would expose the fascial space to see if there is infection before incising the tendon sheath.

DR. Murphy: I agree completely with the initial treatment but I would add a word of caution: in human bite infections, after initial treatment and after the acute process has quieted down, I would wait at least a year before attempting reconstructive surgery. Experience indicates that if these wounds are reopened too soon, the tenosynovitis recurs.

DR. Boswick: What is the prognosis for a useful finger in these cases?

Dr. Schneewind: It is very poor. In this case it looks as though amputation may be necessary. I might add that we always have been taught to operate as soon as a diagnosis of acute tenosynovitis has been made. I have encountered patients in whom this diagnosis cannot be made with certainty, and I have placed them on antibiotics to see if the infection could be resolved. I think that if this is done intelligently and the patient observed carefully, no harm will result; not every finger sustaining this type of injury is an acute tenosynovitis and some of them will clear up. I must emphasize that this has to be done with extreme care. If one is not sure whether pus has accumulated in the palm, it might be well to open the palm first. If there is no pus, then this site can be protected and a mid-lateral incision made subsequently.

Dr. Boswick: What kind of anesthetic is used?

Dr. Stromberg: I use a general anesthetic in these cases.

Dr. Boswick: What antibiotics do you use? Dr. Murphy: I use a large dose of wide spectrum antibiotic, preferably chloromycetin.

Dr. Schneewind: We have mentioned here prophylaxis of tetanus but it is not necessary or wise to assume that this is always done. We must be absolutely certain that these patients receive tetanus toxoid; whether or not they should receive tetanus antitoxin requires individual assessment and proper judgment.

Dr. Boswick: The next patient (Fig. 5) presented with this laceration about five hours after it was sustained with a clean knife. The



FIGURE 5. Laceration distal interphalangeal joint — loss of flexion distal phalanx.

wound had been protected with a sterile dressing and appeared clean, but the distal phalanx could not be flexed. There was no loss of sensation.

DR. MURPHY: In a clean incised wound of this type, one must again determine where it occurred. Was it on the job?

Dr. Boswick: It occurred in a kitchen with a clean knife, and a sterile dressing was applied immediately.

Dr. Murphy: This looks like the type of tendon injury that can be treated primarily under proper conditions in the operating room. It must be determined whether to suture primarily or attach the profundus itself to its distal attachment. I think it is at the level of the distal flexor crease, and in this type of injury I would use a pull-out wire, take the end of the profundus and sacrifice the distal stump, reattaching by drilling a hole through the phalanx, pulling out the wire, and fastening it on a button over the nail. The hand should be immobilized and the fingers put in mild flexion. The distal joint has to be protected because there will be tension in flexion.

Dr. Stromberg: I imagine this is one place where the pull-out wire works very well. I would differ only in putting the suture on either side of the phalanx rather than going through and trying it on the nail, but this is a minor variation. What is important is the idea that a tendon injury at this point can be

treated primarily and well with the expectation of good results. I would like to ask: How far can a profundus be advanced? How far have you advanced it?

DR. MURPHY: This is the limit. You cannot increase it more or you will have too much flexion contracture when you are through.

DR. Boswick: If it is more than 1 cm. from the crease can it be advanced?

Dr. Murphy: No, I do not think it can be advanced beyond that. These patients have permanent deformity of the joint and cannot straighten it out even with this amount of advancement; there is some flexion but it is not really disabling.

DR. Boswick: This is an example of a clean injury that can be repaired and it illustrates what can be done primarily. The type of material is not important. What is important is knowing what to do and what you need to do in a specific injury. How long is an injury of this type immobilized in flexion?

Dr. Murphy: I would leave it on four weeks. Then I would take the splint off, allow the patient restricted motion for another week or 10 days and then permit unrestricted motion.

QUESTION: What if the patient has arthritis? Dr. Murphy: This is a problem; if immobilized too long, the joint surely stiffens. If the immobilization apparatus is removed too soon, the joint may pull away. I do not remove any sooner than three weeks and preferably four, even in the arthritic.

Dr. Boswick: I want to point out that Dr. Murphy said he would immobilize with plaster but I believe the others would use another type of immobilization.

Dr. Schneewind: I think that an aluminum splint would be easier for me. It is just a matter of easy use.

Dr. Stromberg: We keep re-using these aluminum splints all the time. I think that it is an economic factor.

QUESTION: What is the time limit for instituting primary repair on a clean cut like this?

Dr. Stromberg: The teaching is two or three hours, but with proper care and if the injury has not been aggravated, eight hours could elapse without danger. We worry more about wounds that have been aggravated. When this occurs it is not certain whether or not it was

examined under sterile conditions. This would contraindicate a primary repair more than would the time limit.

Dr. Boswick: Dr. Murphy, may we hear about the pull-out wire technique?

Dr. Murphy: The tendon is drawn out and a stainless steel wire on a double loaded needle is interwoven through it. Then, a hole is drilled through the phalanx at a point near the original attachment of the profundus. The old tendon is cleaned out so you have a fresh tendon at the bone attachment. Come through the back of the nail with a drill to form a channel. The strength of the wire is 36 to 40, we use 38, and that goes through the skin. I like to pull it in a fairly straight line. I give a little tug to see if it will slide nicely before I put it around the button on the nail. We draw it up snug so that it hugs the bone, then we put it over the shirt button that has been attached to the nail and tie it down. We leave an extra loop about one inch away so that when the patient comes to the office we don't mistake it for something else and snip it too soon. The pull-out wire is drawn out through the skin on a separate needle, pulled through and left free. This joint will be in flexion when the profundus is attached at about 30 or 40 degrees.

QUESTION: What are the indications for sacrificing the distal stump of the tendon?

Dr. Murphy: This is not necessary. One excellent technique is to make a V wedge and leave the attachment you have. Another surgical philosophy is that fresh tendon will heal to bone just as well as and maybe better than tendon-to-tendon at that point. However, when a V wedge is used it is possible to scrape the bone and get a partial bone attachment. I think it is a matter of technique and I would not debate that. I feel safer when I have a pull-out wire over the button.

QUESTION: Would you think it is worthwhile doing a secondary repair on such a wound if you could not do primarily with the little increase you will get in function of the finger?

DR. MURPHY: If for some reason this wound cannot be adequately repaired, advance that profundus because you will find it trapped at the bifurcation of the sublimis.

QUESTION: What if you could not advance it? Dr. Murphy: Then you would have to decide

to do either arthrodesis or tenodesis. I would not sacrifice a normal sublimis in this type of injury.

DR. STROMBERG: What about an arthritic process here? What you could do then is to suture the skin and then do a tenodesis or arthrodesis secondarily. This you could hold with wire and leave the rest of the hand free and not worry about the other joints.

Dr. Boswick: The next patient presented 12 hours after sustaining this injury while working as a carpenter (Fig. 6). He could not flex the proximal or distal joints of the injured finger. The finger was in hyperextension and the wound seemed to go toward the metacarpophalangeal joint with injury to this joint. There was no loss of sensation in the distal part of the finger.



FIGURE 6. Avulsion injury proximal phalanx — loss of flexion at both interphalangeal joints.

Dr. Schneewind: It appears that this patient has sustained division of both the sublimis and profundus tendons in the sheath area and has not had injury to the digital nerves. In general, I do not believe that primary repair should be undertaken of such injuries. This wound should be adequately cleaned with the best facilities available and I believe that the skin should be sutured. If the injury had been sustained in a garage, I probably would treat this patient with antibiotics and tetanus toxoid.

Dr. Boswick: Dr. Stromberg, would you agree that these tendons should not be repaired at this time?

Dr. Stromberg: Yes, because the injury is in the so-called "no-man's land" and that is a contraindication to primary tendon repair.

Dr. Murphy: I agree.

DR. Boswick: As for tetanus prophylaxis, do you imply you would not use tetanus antitoxin in this type of wound?

DR. SCHNEEWIND: We are using tetanus antitoxin less and less. I probably would not use it here. If this patient has ever been immunized for tetanus I would not use antitoxin, but would give a booster dose of toxoid. Formerly, we thought that four or five years was the limit but it appears that a titer of antibodies is present for many years. The difficulty arises in the patient who has never been immunized or does not know. In this case I would not give antitoxin because of the obvious danger of anaphylactic reaction. The other point is that Clostridium is successfully treated by broad spectrum antibiotics, even 12 hours after it infects a wound. If you kill the bacteria they will not make the toxin, and the antitoxin is only a therapeutic means to treat the liberated toxin.

DR. Boswick: Would this be general policy? DR. Schneewind: I would like to see this adopted. This follows the recommendations of the Committee on Prophylaxis of Tetanus of the American College of Surgeons.

Dr. Boswick: The next patient was injured in his home with a clean knife 10 hours before being seen. (Fig. 7.) The wound was well protected before the man was seen. There is



FIGURE 7. Palmar laceration proximal to the index finger — loss of finger flexion.

an injury across the palm; the third, fourth, and fifth fingers flexed well but the index finger did not. We thought it was a flexor tendon injury in the palm with digital nerve injury in the same area.

Dr. Stromberg: With laceration in the palm, primary tendon suture end-to-end can be done. With one finger involved I think that both tendons can be repaired. If several tendons

are involved I would probably repair only the profundus. They would all become caught in the scar if too many were repaired in the same area. Both the profundus and sublimis have been cut here. Usually, the patient can bring the finger up to the metacarpophalangeal joints; only active motion at the distal joint is gone. I would do primary end-to-end suture of both tendons and repair the digital nerves.

Dr. Boswick: This patient was seen in the emergency room one hour before surgery, and in the emergency room a sterile dressing had been applied. What examination should be done before surgery in these cases?

Dr. Stromberg: You can look at the wound but don't look into it before you are properly set up. If the patient comes into your office and you are going to send him to the hospital, do not use novocaine and retract the skin edges. The tendon injury is obvious. You can tell that by asking the patient to flex the fingers at the joints. You can go over the fingers from a sensory standpoint with a sharp point of some sort. When you do this, make certain that you compare your findings with a normal finger. Do not just ask the patient if he feels it. He will invariably feel it, even with complete division of the nerves. He will say yes, and you will assume that the nerves are intact. To look at the wound is proper only when you want to see the extent of the wound and decide whether it is going to need a lot of debridement, and whether you are going to have to shift the skin to close it. I would immobilize the part for not less than three weeks, then

have the patient start gentle active motion, replacing the splint during the day but primarily at night for one week and after four weeks, no more immobilization.

Dr. Boswick: This type of injury is not unusual to see at this institution at night. What if more than one sublimis is injured?

Dr. Murphy: My experience is that we tend to underestimate the extent of damage. I have had the experience of looking at the attitude of the hand, seeing a digit stuck out in that fashion, and I fully agree that one should not aggravate the wound, since irreparable crippling can result. The attitude of the hand indicates that there is pathology but it is easy to underestimate this. When you explore the wound you will find the sublimis and profundus are three-fourths cut through but still function; looking at the attitude will indicate that it requires surgical attention. At that level in the palm, provided there is no crush element and if there is a good time element, it should be repaired.

Dr. Schneewind: I would limit the repair of the sublimis and profundus to one finger. I would try to separate the two suture lines and I would like to emphasize Dr. Murphy's point: even with the tendons completely divided the extensors can deceive an observer into thinking there is motion; therefore I re-emphasize Dr. Murphy's observations about the attitude of the hand. If there is any doubt, perform the operation.

Dr. Boswick: I would like to thank the participants for this excellent discussion.

A Growing Problem

Simply stated there are and will be more and more people living longer and longer, with fewer and fewer families willing or able to provide love, shelter, and financial support. Politicians have caught the radio and TV "give away" fever. They think that by giving more money and cut-rate hospital care they have the answer to the problem. Emphasis has been placed on means of segregating the aged and stripping them of their ability to earn. The Social Security device had as one of its original

intents to limit the labor market to those under 65 years. Now, again labor is pushing this "heartless" legislation which will in fact allow each family to pass on to the government its responsibility of "home care" of the aging parent. There has been little attention to the study of the desires of the aged, less to the happiness of the aged, and least of all to the type of health care the aged want or require. Philip P. Thompson, Jr., M.D. The Dependent Decrepit and the Happy Oldster. J. Maine M. A. August 1961.

similar episodes on previous occasions. Her father had the same symptoms, and his death was due to a severe hemorrhage from the nose.

The physical examination showed a well developed, well nourished female, who appeared markedly pale and weak. Areas of telangiectasis were noted on the upper and lower lips and on the mucous membranes of the mouth, tongue, and nose. Cutaneous telangiectasis was present at the right index and middle finger.

What is your diagnosis?

- 1. Bronchogenic carcinoma
- 2. Lung abscess
- 3. Pulmonary infarct
- 4. Pulmonary arteriovenous fistula (continued on page 383)

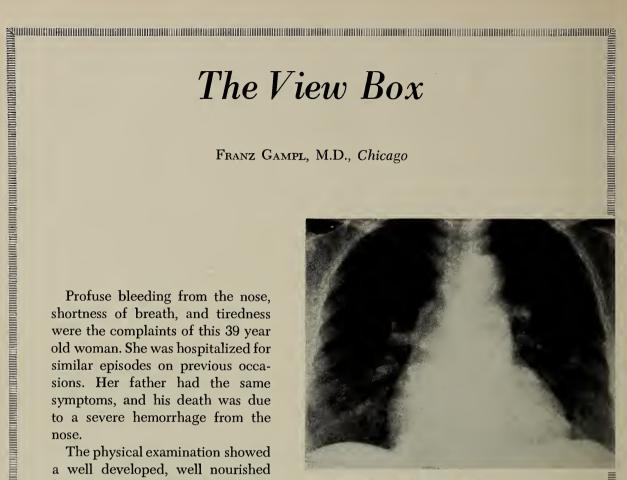
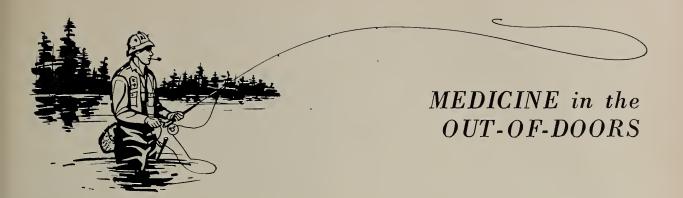


FIGURE 1. Chest roentgenogram taken on admission.



FIGURE 2. Cut out from the left lower lung field.

From the radiology department, Cook County Hospital



A Youngster's First Camp

Julius M. Kowalski, M.D., Princeton

PARENTS OF GROWING CHILDREN are continually beset by the perplexing problems and endless changing situations in the home, neighborhood and school which demand new solutions. With infants and toddlers parental control of the circumscribed environment is relatively easy feeding, changing, countless daily admonitions — do's and dont's — and the court of last resort for mandatory obedience is the flat of the hand on the youngster's posterior anatomy. In a few fleeting years the youngster approaches the turbulent teens. The raised voice, appeal to reason, or even importunings are at times unavailing in disuading a stubborn disposition from a once supple child. Haunting, disquieting thoughts, of many months' duration frequently bring distraught parents to their family physician for a "talk" about Johnny. The hour of reckoning is here.

The precipitant in this smoldering situation was Johnny's bold announcement that he was going to summer camp this year. The kids in his fifth grade class at school were talking about going to camp and so is he; which camp, with whom he would go, or for how long he doesn't know, but he was going to camp! Such unheralded reactions have a way of creeping up on many families, resulting in a quick shuffling of thoughts, queries, reminiscences and mixed reactions. There is now a strong strain on the proverbial parental leash. Suddenly the realization is present that as one decision is reached several new unanswered problems will arise.

The camp. Which camp? Scout, "Y", 4-H, church camp? There are many camps, but what counts is the personnel and its competence. Are the supervisors well-trained, experienced? What are the camp activities and how and by whom are they managed? What is the maximum number of participants in any given group? Are only a few "champs" eulogized, or is some form of recognition given to all participants? Are swimming, boating, and water front activities supervised by qualified personnel? How does the camp director deal with a recalcitrant or bashful child? How many hours each day are the youngsters on the go? Are rest periods mandatory for all? What alternative programs are substituted in the event of prolonged rain or cold weather? Are there many or few returnees to this particular camp? Did some of the present counselors have a part of their early camping here?

The physical plant of the camp needs investigation since this is home away from home, at least for a while. Water supply and sanitary facilities all too often are assumed by parents to be adequate and proper for youngsters, when in reality they are not. These and bathing facilities should meet state or local health standards, and posting of certificates to this effect in conspicuous places on the premises is often required.

Inquiries should be made concerning the mess hall, food storage, refrigeration, food handlers, utensil cleansing, garbage disposal, screening, scrubbing and spraying. Because a

camp publicizes an appealingly balanced diet, with seconds, prepared by a recognized chef, parents may overlook the more prosaic, but nonetheless important, aspects of its preparation.

Information about the units, tents or bunking quarters, their capacities, and persons in charge should be sought. Youngsters literally sleep like babes after a full day of camp activity, be it on the ground, floor or cot, but responsible persons should sleep nearby throughout the night for many reasons.

All good camps require a physical examination of their applicants, including a history, immunizations, and an evaluation concerning physical activity. Such information is meaningful to the camp authorities and the local physician who must minister to a stricken camper. The American Academy of Pediatrics has developed an excellent camp physical form. Some camps offer accident insurance to their campers similar to school accident contracts. More often than not, parents are totally responsible for any medical attention their child may need or any liability arising from his acts. To avoid misunderstanding, answers to all these questions, and many more, should be sought before a contract is signed.

But how will the youngster react to all this, his first real experience away from home and family, among strangers? Will he be homesick?

Can he acclimate, carry his load, keep from harming himself or others? Happily, in the vast number of cases, parental anxieties concerning their children in well-supervised camps are without basis in fact. Children possess a boundless capacity for adjustment under such appealing circumstances. Naturally there will be some nicking of flesh, perhaps status deflation, but on the whole there will emerge a reintegrated, vibrant personality from this new experience.

This will be so, despite the fact that some parents are so woefully lacking in maturity that they expect the school system to teach, entertain, discipline and build character in their children during the few hours in attendance. Other parents are so demanding of immediate results from children that few or none evolve. Excessive criticism stifles initiative and reinforces negativism. The slower tempo of grandparents or other elders may explain why youngsters often learn better under their care.

In a family where parents have a genuine respect for each other and the occasionally arising divergent views; have the courage of their convictions and abide by a compromise; where honesty, sincerity and acceptance of reality prevail; in that family a child will not understand all these basic forces, but he will sense them. This is his fortress of security and reservoir of strength. Have no fears for him as he enters his first camp or the world.



According to the ISMS Constitution . . .

Chapter XI. Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the councilor of the district in which his county is situated.

The View Box—diagnosis and discussion (continued from page 380)



FIGURE 3. Large arteriovenous communications are shown in both middle and lower lung fields.

The diagnosis is pulmonary arteriovenous fistula.

Roentgen findings: A nodular, sometimes lobulated "coin lesion" which is in close connection with one of the larger or smaller branches of the pulmonary artery is characteristic. Pulmonary arteriovenous fistulas can occur at any location, but are more frequently found in the middle and lower lung fields. Multiple lesions of varying size may affect one lobe or one lung. Bilateral involvement as seen in our patient was not apparent on the plain chest radiographs but was obvious on angiography. (Figure 3 shows multiple large arteriovenous communications in both middle and lower lung fields.) On fluoroscopy, the size of the lesion diminishes with increase in intrathoracic pressure (Valsalva maneuver). Forced inspiration against a closed glottis will increase the size of the lesion (Müller maneuver). Laminographic studies demonstrate the close connection between the large pulmonary "feeding" vessels and the arteriovenous malformation.

Discussion

The size and number of shunts determine the clinical symptoms. Large communications of the pulmonary artery with the pulmonary veins allow significant amounts of unoxygenated blood to return from the lungs into the systemic circulation.

The oxygen saturation in the peripheral blood is decreased. Dyspnea, cyanosis, and clubbing of the fingers and toes will develop. Secondary polycythemia is a frequent finding. A bruit may be heard over the site of the fistula on auscultation. Arteriovenous malformations of the lung may occur isolated or in conjunction with telangiectasis on mucous membranes, the skin, and the intestinal organs as part of a dominant hereditary syndrome (Olser-Rendu-Weber).

Fatal complications include meningitis, brain abscess, and cerebral thrombosis. Right heart failure due to the increased load upon the right ventricle may also enter the picture.

Treatment: Symptomatic, isolated fistulas in the lung lend themselves to resection.

REFERENCES

- Muri, J. W.: Arterio-venous Aneurysm of the Lung, Am. J. Surg. 89:265-271 (Jan.) 1955.
 Stern, W. E., and Naftziger, H. C.: Brain Abscess Associated with Pulmonary Angiomatous Malformation, Ann. Surg. 138:521-531.

Unnecessary Examinations

One serious by-product of over-utilization of health policies that has received scant (and merits much more) attention is the effect on the medical attendant. Performance of unnecessary examinations by an already overworked physician is bound to be reflected in his attitude towards his work, which unfortunately might be carried over into other, more legitimate areas of medical practice. Less important, but, in my opinion, real, is the frame of mind of

some of these patients undergoing unnecessary examinations that entail discomfort; although it is possible that my clock of forebearance is winding down along with the ticking away of time, I do feel more and more patients are protesting the admittedly strenuous preparation for a barium enema, or the chalky suspension for the gastrointestinal series. Christian V. Cimmino, M.D. Editorial. Health Insurance and the Principle of "Tolerable Pain." Virginia M. Month. January 1961.



Editorials

The Physician Image*

As the twentieth century emerged on the horizon of time, the physician occupied a unique position; "the great and honored healer" was looked up to and respected wherever he practiced.

What is our image now, in a century where the profession has lengthened man's life span and has wiped out many horrible diseases? Is there really a poor image? Or is there an artificial picture portrayed by the mob-arousing yellow journalist or the power-hungry politician? Or is there an image naturally developing in a society where the unfortunate "It's coming to me" attitude is becoming more prominent? We seem to live in a world where pride in workmanship, personal responsibility for one's elders, and the desire for more "free time" (dislike of work?) is becoming more and more the common feeling rather than the unusual.

I should like to cite a true story that occurred in our community to one of our more public spirited physicians. This doctor overheard a young woman complaining that her sick mother was unable to obtain any physician. He immediately offered his services (free, too!). On entering the patient's home he was confronted by an elderly, somewhat ill woman who was violently opposed to all physicians. After his physical examination he inquired as to the circumstances under which she was unable to obtain a doctor. It turned out that she had phoned three doctors (there are 63 in the phone book), all of whom refused to make

the house call. When this physician suggested the names of additional doctors, the patient refused each with such remarks as "I don't want him, I remember his father," "I don't want him, he's too young," etc. The patient also stated that she wanted a physician who would be "respectful" to her and not one that would "order" her about. Finally, she accepted a list of fourteen doctors whom she "did not know" and promised that in the future she would contact one of them for medical care. Interestingly enough, when asked if she were the physician would she respond to a call for a patient like her, her answer was, "I should say not - but I'm not a doctor." Our public spirited physician hopes that he has in some way changed the doctor image that this woman's daughter had. As for the patient herself, senility could be classified as her excuse.

Selling a pretty picture of the doctor to the public is (to me) a waste of time, money, and effort. Each and every one of us must do the best job possible and follow the terms of the Hippocratic oath. Sigerist, the famous medical historian, has already forecasted a socialistic medical state as being inevitable. I hope he is wrong, but until time proves or disproves his theory let us as individuals "get behind the bat and hit home runs" for our patients. Let us do the best we can, let us be honest with the public and ourselves, and I feel that the "physician image" will take care of itself.

^{*}Reprinted by permission from the Quincy Medical Bulletin, XXXVII:4 (Feb.) 1962

Need for New Medical Schools

The Association of American Medical Colleges estimates a need for facilities to accommodate 4,000 additional medical school students in opening enrollments by 1970. A recent survey of existing facilities shows that 1,700 additional students could be accommodated by expansion and renovation, but that new schools will be needed to provide space for the remaining 2,300 students. This means that on the basis of an average of 100 graduates a year, 23 new schools must be admitting freshmen by 1970. The association estimates that it will cost \$518 million for new construction, expansion and renovation of existing facilities. In addition, they estimate that each new medi-

cal school will cost \$30 million, which includes facilities for basic science and clinical teaching. The total cost to bring us up to par by 1970 would be somewhere in the neighborhood of \$1,208 million.

This does not include renovation and remodeling costs of existing teaching hospitals or land acquisition and development expenses.

This is only a part of the story because the 23 new schools will need new faculties. In addition, 2,300 highly qualified premedical students will be needed to fill the new classes. This is a tremendous undertaking unless we reduce our standards or better, reduce the number of years of premedical training at the college level.

Itching Folklore Persists

On the basis of clinical observation, many diseases have been said to be associated with pruritus. No long term studies have been put forward to substantiate such associations, yet in many instances the myth of such relationships persists as part of medical folklore. An excellent example of this pertains to gout. Goldsmith quoted Lord Horder as considering gout the most frequent cause of itching, and stated that in 33 per cent of a series of patients with

pruritis the level of uric acid was more than 3.7 mg. per 100 ml. of serum. Cinchophen was said to relieve some of the itching. This information has been repeated over and over in medical publications without adequate clinical evaluation. No modern treatise on the gouty patient includes description of pruritus as a primary symptom. Richard K. Windelmann, M.D. Dermatologic Clinics. 1. Comments on Pruritus Related to Systemic Disease. Proc. Staff Meet. Mayo Clin. April 12, 1961.

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MINERAL OIL LABELING

The FDA has tightened its regulations relative to the labeling of mineral oil. Their nutritionists claim that it is unsafe as a food additive because it inhibits the absorption of fat soluble vitamins, particularly A and D. There are no regulations or exemptions in effect for its use as a salad oil, but it may not be legally sold for that purpose. They recently seized 140 gallons of mineral oil, claiming that the label falsely claimed that it was adequate for chronic constipation, intestinal disorders (as well as being excellent for use as a nonfattening oil in salad dressings). The agency also charged that "the label failed to bear warnings that mineral oil should be taken only at bedtime, that it is not for prolonged use and that it should not be given to infants or youngsters, in pregnancy or to bedridden or aged persons unless directed by a physician."

We wonder occasionally how our present crop of nine million oldsters ever made the grade considering the popularity of mineral oil in their day. Many of these old-timers drank mineral oil until it ran out the rectum. Past experience means very little to the FDA, but there is no need to get excited because better laxatives are available. Furthermore, getting excited is likely to do more harm than a gallon of mineral oil.

LESS BEDS FOR TB PATIENTS

During 1961 two institutions in Cook County closed their tuberculosis services and are utilizing the beds for the care of acute and chronic diseases. They were the chest hospital facility at Oak Forest, with 64 beds, and the 49-bed chest disease ward at Cook County Hospital.

The need for beds for TB patients has diminished not from a rapid decline in cases, but because the average length of stay has been shortened. This average used to be two years, but within the last decade it has dropped to nine months or less.

More Foreign Doctors Needed

We were informed by the Public Health Service that American hospitals are increasingly dependent upon graduates of foreign medical schools to help fill their house staff positions. According to a release there were 2,100 foreign graduates interning and holding residencies in 1951 as compared with 9,500 in 1960.

This occurred despite the fact that the number of medical school graduates has increased about 40 per cent since 1940. But during these two decades the number of internships offered increased almost 90 per cent.

TRANSISTORIZED AUDIOMETER

Otarion Electronics, Inc. introduced recently a portable transistorized audiometer with a tape deck. The machine (1100-T) permits tests of hearing by air conduction, bone conduction and free field. It meets all specifications of the Acoustical Society of America and is designed as a low cost hearing loss analyzer for use by physicians, audioticians and hearing aid specialists.

HEALTH INSURANCE INCREASE

According to Health Insurance News, an estimated 136 million Americans had hospital insurance by the end of 1961. Approximately 124 million had surgical and 91 million had

regular medical insurance. But the greatest increase during the past year was noted in major medical insurance; thirty five million have this type of insurance, an increase of more than seven million since 1960.

Health insurance protection over the past decade has grown at a rate more than triple the civilian population explosion. Our U. S. civilian population increased 17 per cent, whereas health insurance protection increased 55 per cent. For most physicians, this means a 1,000 per cent increase in forms to be filled in.

MMA "BRANDED"

The Montana Medical Association does not operate a ranch or own cattle, horses or sheep, but they expect to publish a book in the future, and had their "Lazy MD" brand registered in the office of the General Recorder of Marks and Brands for the State of Montana. The brand will be burned on the cover of the special limited edition which will be hand-bound in fawn deerskin. The book is entitled "Medicine in the Making of Montana" and covers medical practice from the time of the Lewis and Clark Expedition through the fur-trading and gold rush days that followed.

PHARMACEUTICALS

Three Pfizer Laboratories products (Terramycin, Vistaril, and Streptomycin) will be available in a completely disposable, prefilled sterile syringe and needle unit. The latter is known as Isoject and incorporates a number of safety features designed to insure sterility — and, we hope, sharp needles.

ONE-STEP BLOOD WITHDRAWAL

The Vacutainer is Mills' new specimen collection device that eliminates the multi-step procedure of taking blood samples. It consists of an evacuated sterile glass tube with needle all in one unit. The needle and evacuated tube are separated by a thin rubber diaphragm. "After the needle is in the vein," according to a news release, "a slight forward push on the tube punctures the rubber diaphragm, releasing the vacuum which draws blood into the tube."

This is automation on a small level, but we doubt if the person writing the release ever drew blood by the old or conventional method. "Using the Vacutainer, a blood sample can be collected with one hand and in one easy step, leaving the other hand free to locate and palpate the veins."

COMPACT CONVULSIVE THERAPY

There is an old story about a man walking down the street carrying a couch on his head. "A psychiatrist making a house call" was the logical explanation. We were reminded of this when we saw a release from CGC Medical Electronics, Inc. They have two small portable compact electro-shock therapy instruments. One is for convulsive therapy only, and the other is for combination Glissando-Convulsive therapy.

PLASTIC SURGICAL DRAPES

The 3M Company introduced impermeable plastic surgical drapes that are presterilized and backed with metered adhesive coating for easy application. They have been treated to reduce the possibility of build up of static electricity.

LARGEST X-RAY USERS

We learned from the Chicago Dental Society that dentists are the largest single profession using x-ray equipment. They have 57 per cent of 7,100 registered installations in Illinois dental offices. In addition, dentists discovered more than 600 cancers in oral examinations of Veterans Administration patients between 1956 and 1958.

ACS NATIONAL MEETING

Several interesting papers were given at the last national meeting of the American Chemical Society. T. C. Huang, director of research of Timken Mercy Hospital, Canton, Ohio, told of a new simplified test for cholesterol. This one-step method measures in an hour both free and esterified cholesterol. We are in need of a simplified test in order to obtain standard values for cholesterol levels in the blood.

Dr. William H. Fishman, research professor of oncology at Tufts University School of Medicine, predicted that physicians may be able to diagnose intestinal ailments without x-ray or surgical studies in the near future. It will be done via a new method for measuring enzymes.

A California chemist isolated a plant hormone that can make the cocklebur bloom out of season. The hormone, florigen, may allow growers to time the production of plants and prevent flowering in crops grown solely for their leaves or stalks.

AHR-619 is a new agent that counteracts overdoses of sleeping pills, alcohol, and morphine in animals. Dr. Carl D. Lunsford reported these observations before the American Chemical Society. In his opinion it is the most potent drug ever tested for combating barbiturate intoxication in dogs.

LUNCH PROGRAM ANNIVERSARY

This is the 15th anniversary of the National School Lunch Program. It is in operation in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam. Approximately 13½ million children participated last year.

COMPUTER TO AID IN CANCER THERAPY

A Bendix G-15 computer system is being installed in the Memorial Sloan-Kettering Cancer Center. It will be used in applying data processing techniques to the study of radiation in diagnosing and treating cancer. The initial determinations will center about such information as the amount of radiation from external sources delivered to cancer tissues and to surrounding normal tissues, and distribution of radiation by radioactive needles and seed implants.

NEW APPARATUS CATALOG

The Chicago Apparatus Company Catalog 62 now contains a completely rewritten 1,600 page presentation of laboratory instruments, apparatus, and supplies. Designed for utmost convenience to the user, information is systematically

organized, easily located, extremely detailed, and entirely factual. The index is exhaustively cross-referenced and includes major manufacturers' numbers for easy conversion.

It will be sent to those requesting a copy on their business or professional letterhead and where practical use may be anticipated.

BOOK PORTRAYS MED STUDENT

A recent book, "Boys in White: Student Culture in Medicine," is reported as having captured the interest of pre-med and medical students, as well as medical educators.

The team of sociologists who collaborated on the book attempt to answer the many questions posed by the medical student. The authors try to catch the worries, cynicism, and basic idealism of the students and also document many other realities of medical education in relation to society.

The 455 page volume is priced at \$10 and can be purchased from the University of Chicago Press.

TEACHING THE DIABETIC

The Committee on Professional Education of the American Diabetes Association recommends the following nine points as an aid in systematically teaching the patient how to manage his diabetes:

- 1. Diet
- 2. Urine testing
- 3. Action of insulin and other hypoglycemic agents
- 4. Technique of insulin injection and sites for it
- 5. Care of syringe and of insulin
- 6. Symptoms of hypoglycemia
- 7. Symptoms of uncontrolled diabetes
- 8. Care of the feet
- 9. What to do in case of acute complications

BOOKLET ON CROSS-INFECTION

Anyone desiring the latest information on "cross-infection" can get it by writing for the booklet, "Preventive Procedures for Combating Cross-Infection." It is obtainable through Hospital Bureau, Inc., 60 W. 55th St., New York 19. The price is \$2.

ILLINOIS STATE MEDICAL SOCIETY



122nd Annual Meeting Sherman House Chicago, Illinois May 13-17, 1962

Program Summary

		1	
	Sunday, May 13	1:30	Section on Neurology and Psychiatry
11:00 a.m.	Reference Committee Chairmen	0.00	Crystal Room
2:00 p.m.	Time Room #110 Illinois Medical Political Action Committee	6:00	University of Illinois School of Medicine Alumni Dinner Louis XVI Room
	Crystal Room	8:15	Illinois Chapter, American
4:30	Council Meeting Gold Room #114		College of Chest Physicians – Round Tables
6:00	Credentials Committee Foyer of Louis XVI Room		Grand Ballroom **Illinois Surgical Society meets
7:00	First Session House of Delegates Louis XVI Room		in separate session Cook County Hospital
9:30	Bierstube for Officers,		**Illinois Obstetrical and
	Delegates and Guests		Gynecological Society meets is
	George Bernard Shaw		separate session
	Room		Louis XVI Room
	**Illinois Society of		
	Anesthesiology meets in separate session		Tuesday, May 15
		8:00 a.m.	Council Breakfast
	Monday, May 14		Ruby Room #113
8:00 a.m.	Council Breakfast	9:00	Joint Meeting Ob-Gyn and
0:00 a.m.	Ruby Room #113		Dermatology Crystal Room
8:00	Registration Opens	9:00	Section on Allergy
9:00	Reference Committees		Louis XVI Room
12:00 noon	Exhibits Open Mezzanine	9:00	Section on Public Health and Preventive Medicine
12:00 noon	Public Relations and Medical		Jade Room #103
	Economics Institute Gold Room #114	11:00	Section on Ob-Gyn Crystal Room
1:00 p.m.	Section on Anesthesiology	11:00	Section on Dermatology
	Ruby Room #113		Gold Room #114

Convention Manager	OFFICES	
Registration	Mezzanine	
Convention Manager	Mezzanine	
Press Room	Polo Room #102	
Business Office	Emerald Room #104	

in

12:00 noon	Fifty Year Club Luncheon Ballroom	12:00 noon	Public Health Luncheon Gold Room #114
1:30 p.m.	Section on Radiology Crystal Room	12:00 noon	Illinois Society of Internal Medicine Luncheon
1:30	Panel on "Cough"		French Room #107
	Louis XVI Room	1:30 p.m.	Oration in Medicine
3:00	Panel on "Shoulder-Arm Pain"		Ballroom
4.00	Louis XVI Room	2:00	Camp Memorial Lecture
4:00	Panel on "Post-Operative	0.15	Ballroom
	Problems" Louis XVI Room	3:15	Oration in Surgery Ballroom
6:00	Section on Pathology Dinner	5:00	Section on Physical Medicine
0.00	Jade Room #103	3.00	and Rehabilitation
6:30	Credentials Committee		Gold Room #114
	Foyer to Louis XVI Room	6:00	Social Hour
7:00	Second Session		Louis XVI Room
	House of Delegates	7:00	Annual Dinner
	Louis XVI Room		Ballroom
W/ 1 1 14 4.			
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W	'ednesday, May 16	•	Thursday, May 17
8:00 a.m.	Council Breakfast	8:30 a.m.	Thursday, May 17 Impartial Medical Testimony Breakfast
			Impartial Medical Testimony
8:00 a.m.	Council Breakfast Ruby Room #113		Impartial Medical Testimony Breakfast
8:00 a.m.	Council Breakfast Ruby Room #113 Section on Pediatrics	8:30 a.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room
8:00 a.m. 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room	8:30 a.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of
8:00 a.m. 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of	8:30 a.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates
8:00 a.m. 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress"	8:30 a.m. 8:30 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room
8:00 a.m. 9:00 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases"	8:30 a.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the
8:00 a.m. 9:00 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular	8:30 a.m. 8:30 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities"
8:00 a.m. 9:00 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General	8:30 a.m. 8:30 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities" Ballroom
8:00 a.m. 9:00 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General Practice Luncheon	8:30 a.m. 8:30 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities"
8:00 a.m. 9:00 9:00 10:15 12:00 noon	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General Practice Luncheon Louis XVI Room	8:30 a.m. 8:30 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities" Ballroom Panel on "Hepatitis"
8:00 a.m. 9:00 9:00	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General Practice Luncheon Louis XVI Room Illinois Chapter, American	8:30 a.m. 8:30 9:00 9:00 10:45 12:30 p.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities" Ballroom Panel on "Hepatitis" Ballroom Council Luncheon Gold Room #114
8:00 a.m. 9:00 9:00 10:15 12:00 noon	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General Practice Luncheon Louis XVI Room Illinois Chapter, American Academy of Pediatrics	8:30 a.m. 8:30 9:00 9:00	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities" Ballroom Panel on "Hepatitis" Ballroom Council Luncheon Gold Room #114 Physicians Association of the
8:00 a.m. 9:00 9:00 10:15 12:00 noon	Council Breakfast Ruby Room #113 Section on Pediatrics Crystal Room Panel on "Diseases of Medical Progress" Ballroom Panel on "Cerebral-Vascular Diseases" Ballroom Illinois Academy of General Practice Luncheon Louis XVI Room Illinois Chapter, American	8:30 a.m. 8:30 9:00 9:00 10:45 12:30 p.m.	Impartial Medical Testimony Breakfast Gold Room #114 Credentials Committee Foyer to Louis XVI Room Third Session House of Delegates Louis XVI Room Panel on "Venous Stasis of the Lower Extremities" Ballroom Panel on "Hepatitis" Ballroom Council Luncheon Gold Room #114

There will be a 30 minute break mid-morning and mid-afternoon to permit members to view the scientific and technical exhibits. Everyone is urged to take advantage of this scheduling to visit the exihibits on the mezzanine floor.

2:00

12:00 noon Phi Chi Luncheon

Ruby Room #113

Room

Exhibits Close

Program by Days

MONDAY, MAY 14

Section on Anesthesiology

Freda B. Morgan, Chairman Chicago F. A. Torrey, Secretary Pekin

Ruby Room 113

,	
1:00 p.m.	"Some Recent Studies in Curare * John Schmidt, Assistant Professor of Anesthesiology, University of Illinois
1:20	"Some Further Studies in Acid- Base Balance" Ernst Trier Morch, Professor of Anesthesiology, University of Illinois
1:40	"The Transvaginal Paracervical Pudendal Block — A Movie and Discussion" Max Sadove, Professor of Anesthesiology, University of Illinois; Head of Department of Anesthesiology, Illinois Research and Education Hospital
2:10	"Halothanes in Clinical Anesthesia" John Abajian, Jr., Professor of Anesthesiology, College of Medicine, Burlington, Vt.
2:40	"A Military Type Anesthetic Unit" John Straub, Clinical Assistant in Anesthesiology, Illinois Research and Education Hospital
3:10	"Tham — Animal and Clinical Studies," Reuben C. Balagot, Associate Professor of Anesthesiology, University of Illinois

Section on Neurology and Psychiatry

Louis D. Boshes, Chairman Chicago FRANK B. NORBURY, SECRETARY ... JACKSONVILLE

Monday, May 14

Cr

rystal Ro	om
:30 p.m.	Symposium: "Recent Advances" Sponsored jointly by the Illinois Psychiatric Society and the Chicago Neurological Society, Louis D. Boshes, Moderator "Child Psychiatry,"
	Charles L. Block, Northwestern University Medical School; Evanston Hospital
	"Child Neurology," Douglas N. Buchanan,
	University of Chicago School of Medicine
	"Adult Psychiatry — Newer Drugs," Jackson A. Smith, Clinical Director, Illinois State Psychiatric Institute;
	University of Chicago "Adult Neurology," Robert L. Tentler, Stritch
	School of Medicine, Loyola University; Loretto Hospital
	"Geriatrics," Jack Weinberg, University of Illinois College of Medicine; Michael Reese
	Hospital and Medical Center "Neurosurgery," Milton Tinsley, Chicago Medical School;
	Michael Reese Hospital and Medical Center

1:30 p.m. "Newer Drugs and the Nervous System," Louis D. Boshes, Northwestern University Medical School; Michael Reese Hospital and Medical Center "Liaison Psychiatry," Jerome S. Beigler, Michael Reese Hospital and Medical Center "Disaster Psychiatry Care," Harold M. Visotsky, Director of Mental Health Service, Board of Health, Chicago; University of Illinois, College of Medicine

Illinois Obstetrical and Gynecological Society

Mary Louise Newman,
PRESIDENT JACKSONVILLE
DEANE M. FARLEY,
Secretary Berwyn
Worling R. Young,
PROGRAM CHAIRMAN GENESEO

Monday, May 14

Louis XVI Room

Louis AVI Ko	oom -
9:00 a.m.	Business Meeting and Committee Reports
10:00	"A Sane Sterility Program," Melvin Cohen; Philip Lynch, discussant
10:30	"Unexplained Delayed Bleeding in the Postpartum Period," Henry Hartman, Howard Penning, discussant
11:00	"Maneuver for Inspection of the Postpartum Cervix, and Its Application to Breech Delivery," Earl Blair, Gilbert Edwards, discussant
11:30	"Afibrogenemia," John Rendok, W. C. Scrivner, discussant
12:15 p.m.	Luncheon — George Bernard Shaw Room

2:00 p.m. "Vaginal Examinations During Labor," Lt. Col. William Peterson — Andrews Air Force Base (Courtesy of Illinois State Medical Society) John Standard, discussant 2:30 "Pitfalls in Gynecology," Walter Reich, Mitchell J. Nechtow, discussant 3:00 "Colpocentesis, Colpotomy, Culdoscopy and Colposcopy," Warren Lang — Jefferson Medical School (Courtesy of Illinois State Medical Society) C. O. Smith, discussant

Annual Clinical and Scientific Meeting of the Illinois Surgical Society

Surgical Clinics at the Cook County
Hospital — Monday, May 14
7th Floor, Harrison and Wood Streets,
Chicago, Illinois
Charles B. Puestow,
Chairman of Surgical Symposium

Surgical Amphitheater

8:00 - 9:30 a.m.	Emergency Gastrectomy of Patient with Bleeding Peptic Ulcer Surgeon, Karl A. Meyer
	Discussants, Foster L. McMillan, Kent Barber
9:30 - 9:55	Role of Blood Volume in the Management of Bleeding Peptic Ulcer Peter A. Rosi Discussants, William J. Cahill, Frank Banish
9:55 - 10:20	Surgery of Hypertension Geza de Takats, Ormand C. Julian, Hiram T. Langston
.0:20 - 11:00	Pediatric Surgery, Case Presentation of Surgical

		1	
	Conditions with Discussion of Management John L. Keeley, Paul F. Fox, William L. Riker		Surgeon, Robert L. Schmitz Discussants, Reginald L. Norris, James R. Hines
11:00 - 12:00	Pathology of the Stomach and Duodenum, Clinical Presentation of Cases and Discussion Alton Ochsner, New Orleans, Louisiana	10:00 - 12:00	Surgery for Infections and Injuries of the Wrist and Hand William H. Requarth, Burton C. Kilbourne, William A. Stromberg
1:00 - 2:00 p.m. 2:00 - 3:00	Problem of Anesthesia and Surgery in Aged and Poor Risk Patient Vincent J. Collins, Frederic A. de Peyster Ileus, Potassium	1:00 - 3:00 p.m.	Left Hemicolectomy, Essentials of Radical Colon Surgery Surgeon, Peter A. Rosi Discussant, J. C. Thomas Rogers
2:00 - 3:00	Deficiency, Its Manage-	Opr. Room "C"	
	ment, etc.	8:00 - 10:00 a.m.	Chalagratastamy with
	Kenneth H. Schnepp Discussants, Robert J. Baker, Arthur D. Poppens	0:00 - 10:00 a.m.	Cholecystectomy with Common Duct Exploration Surgeon, E. Lee Strohl Discussants, W. James
Opr. Room "A"			Gillesby, T. Howard Clarke
8:00 - 10:00 a.m.	Indication for Surgery in Jaundice Patient Surgeon, Manuel E. Lichtenstein Discussants, Everett P. Coleman, William M. McMillan	10:00 - 12:00	Radioactive Iodine and Surgery Surgeon, Morris T. Friedell Discussants, Arkell M. Vaughn, David A. Bennett
10:00 - 12:00	Surgery for Pathology of the Breast Surgeon, Joseph E. Silverstein Discussants, Louis P. River, Thomas W.	1:00 - 3:00 p.m.	Nontoxic Thyroid Diseases Requiring Surgery Surgeon, Leon J. Aries Discussants, Howard P. Sloan, Howard H. Hamlin
	Samuels	Opr. Room "D"	
1:00 - 3:00 p.m.	Management of Fracture with Vascular Injury Surgeon, Donald S. Miller Discussants, James K. Stack, James A. Hunter	8:00 - 10:00 a.m.	Cause and Repair of Recurrent Hernia Surgeon, Samuel J. Fogelson Discussants, Chester C.
Opr. Room "B"		10.00 12.00	Guy, Bernard J. Doyle
8:00 - 10:00 a.m.	Surgery for Benign Lesions of the Colon	10:00 - 12:00	Benign Thoracic Pathology Mendable to Surgery George W. Holmes

Discussants, Gustav W.
Giebelhausen, Robert A.
De Bord

1:00 - 3:00 p.m.

Carotid Endarterectomy,
Cerebral Vascular
Pathology
Surgeon, Robert J. Freeark
Discussants, Harold C.
Voris, Eugene M.
Narsete

Opr. Room "E"

8:00 - 10:00 a.m. Total Abdominal
Hysterectomy for
Fibroids, Prophylactic
Ligation of the
Hypogastric Artery
Surgeon, Walter Reich
Discussant, Mitchell
Nechtow

10:00 - 12:00
Vaginal Hysterectomy

with Perineal Repair
Surgeon, Abraham F. Lash
1:00 - 3:00 p.m. Gastrectomy for Peptic

Ulcer Surgeon, Nicholas J. Capos Discussants, William Johnson, James W. West

7th Floor

1:00 - 3:00 p.m. Modern Surgical
Recovery Room,
Inspection, Demonstratration, Discussion
Vincent J. Collins, Ivan
Zahony, Robert J.
Baker

SCIENTIFIC MEETING

Monday Evening May 14, 1962 — 8:00 p.m.

University Club

Michigan Avenue and Monroe Street

Chicago, Illinois

Indications For and Results From Surgical

Treatment of Ulceration of Stomach

and Duodenum

Alton Ochsner, New Orleans, Louisiana

QUESTION AND ANSWER PERIOD
MEMBERS OF THE MEDICAL PROFESSION ARE

INVITED TO ALL SESSIONS

Illinois Chapter
American College of Chest Physicians
Fireside Conferences

Grand Ballroom

8:15 p.m. The Fireside Conferences, to which all physicians are invited, are sponsored by the Illinois State Medical Society and the Illinois Chapter of the American College of Chest Physicians. These informal, unrehearsed conferences provide an opportunity for the free discussion of many subjects of interest to specialists and general practitioners. A panel of experts will be seated at each table and those attending the session are encouraged to ask questions, express their own ideas and comment on the various problems of the subject under discussion. They may move freely from one table to another, if and when they wish. Refreshments will be served with the compliments of the Illinois Chapter of the College.

Subjects and Discussion Leaders

- 1. Pulmonary Manifestations of Systemic Disease

 Moderator: Gordon L. Snider, Chicago Kenneth M. Campione, Chicago Joseph K. Freilich, Chicago Abel Froman, Chicago Hildegarde A. Schorsch, Chicago Quentin D. Young, Chicago
- 2. Bronchiectasis and Bronchitis

 Moderator: Robert W. Carton, Chicago
 William E. Adams, Chicago
 Jack C. Cooley, Urbana
 Noble Correll, La Grange
 Paul H. Holinger, Chicago
 John H. Houseworth, Urbana
 Mario D. Mansueto, Hammond, Indiana
 Albert H. Niden, Chicago
- 3. Chemotherapy of Tuberculosis, Newer Techniques

 Moderator: Karl H. Pfuetze, Chicago

Kenneth G. Bulley, Aurora William Lester, Hinsdale David F. Loewen, Decatur David B. Radner, Chicago David Reisner, Hines Herman C. Rogers, Mt. Vernon Thomas Worobec, Downey

- 4. Thoracic Biopsy Procedures

 Moderator: George W. Holmes, Chicago
 Robert S. Ginsberg, Chicago
 James M. Head, Chicago
 Paul Heller, Chicago
 Robert J. Jensik, Chicago
 Leonard Krasner, Waukegan
 Harold Levine, Chicago
 Peter V. Moulder, Chicago
- 5. FIBRINOLYTIC AGENTS IN CARDIOVASCULAR
 DISEASE
 Moderator: Richard J. Jones, Chicago
 Henry D. DeYoung, Chicago
 John H. Olwin, Chicago
 John T. Sharp, Hines
- 6. Pulmonary Function Tests

 Moderator: Benjamin Burrows, Chicago
 Albert H. Andrews, Chicago
 William M. Lees, Chicago
 Robert S. Mendelsohn, Chicago
 Herbert Newhaus, Chicago
 John F. Perkins, Jr., Chicago
- 7. Sarcoidosis and Pulmonary Fibroses

 Moderator: Robert O. Levitt, Chicago
 Andrew L. Banyai, Chicago
 Johann S. Bornstein, Chicago
 George J. Brebis, Chicago
 Lester Cohn, Skokie
 Peter G. Economou, Chicago
 Eugene L. Walsh, Glenview
- 8. Fungus Infections
 Farmer's Lung
 Moderator: Stanford K. Sweany, Hines
 William B. Buckingham, Chicago
 Joyce C. Lashof, Chicago
 Dan Morse, Peoria
 John J. Procknow, Chicago
 J. Robert Thompson, Chicago
 Morris Zelman, Mt. Vernon
- 9. PNEUMONIAS AND LUNG ABSCESSES

 Moderator: Robert T. Fox, Chicago

David R. Barnum, Evanston Meyer J. Barrash, Chicago Robert A. DeBord, Peoria Kenneth C. Johnston, Chicago

- 10. Atherosclerosis, Prevention and TreatMent
 Moderator: Thomas J. Coogan, Chicago
 Felix P. Ballenger, Captain, MC, USN,
 Great Lakes
 William S. Dye, Chicago
 Benjamin M. Kaplan, Chicago
 Oglesby Paul, Chicago
 Harold A. Shafter, Chicago
- 11. Pediatric Heart Disease

 Moderator: Joseph R. W. Christian,
 Chicago
 Rene A. Arcilla, Chicago
 Arthur DeBoer, Chicago
 Egbert H. Fell, Chicago
 Bessie L. Lendrum, Chicago
 Maurice Lev, Chicago
 Laurence H. Rubenstein, Chicago
- 12. EMPHYSEMA

 Moderator: David W. Cugell, Chicago
 Martin A. Compton, Bloomington
 Burgess L. Gordon, Chicago
 Edwin N. Irons, Chicago
 Morris A. Kaplan, Chicago
 Edwin R. Levine, Chicago
 Irving Mack, Chicago
 Leon Unger, Chicago
- 13. RECENT ADVANCES IN THE MANAGEMENT OF
 CONCESTIVE HEART FAILURE
 Moderator: Oldrich Prec, Downers Grove
 Kurt Biss, DeKalb
 George L. Chesley, Bloomington
 Owen Deneen, Bloomington
 Virgil C. Keeling, Rockford
 Chauncey C. Maher, Chicago
 Peter J. Talso, Chicago
- 14. Advances in Diagnosis and Treatment of Lung Cancer

 Moderator: F. John Lewis, Chicago
 Bertram W. Carnow, Chicago
 Irving M. Greenberg, Highland Park
 Clarence R. Heidenreich, Chicago Heights
 S. Allen Mackler, Chicago
 Douglas R. Morton, Elgin
 Darrell H. Trumpe, Springfield

TUESDAY, MAY 15

Section on Obstetrics	Se
and Gynecology	

ROBERT R. HARTMAN,	
Chairman	Jacksonville
Donald M. Fahrenbach,	
SECRETARY	Chicago

Crystal Room

9:00 -

11:00

10:30 a.m. Joint Meetings with Section on Dermatology

"Diagnosis and Treatment of Vulvitis," Warren Lang, Jefferson Medical College, Philadelphia H. Close Hesseltine, University of Chicago, Samuel Bluefarb, Chicago,

Louis Rubin, Rockford

Robert Lane, Chicago Board of Health, Topic to be Announced

11:30 "Spartocin Sulphate in Inductions and/or Stimulation of Labor"
Lt. Col. William F. Peterson,
USAF, Chief of Ob-Gyn,
Andrews Air Force Base

Section on Dermatology

STEPHEN ROTHMAN, CHAIRMAN CHICAGO MYRON H. KULWIN, SECRETARY CHAMPAIGN

Crystal Room

9:00 -

10:30 a.m. Joint Meeting with Section on Ob-Gyn

"Diagnosis and Treatment of Vulvitis"

Gold Room #114

11:00 "Pathogenetic Factors in Acne Vulgaris," Allan L. Lorincz,
Associate Professor and Head of Section of Dermatology,
Department of Medicine, The
University of Chicago

11:15

"Psychiatric Considerations in Acne Vulgaris," John F. Kenward, Associate Professor, Departments of Psychiatry and Pediatrics, The University of Chicago

11:30

"Treatment of Acne Vulgaris," Frederick D. Malkinson, Associate Professor, Section of Dermatology, Department of Medicine, The University of Chicago

11:45

"Dermahvasion for Acne

11:45 "Dermabrasion for Acne
Scarring," M. Paul Lazar,
Assistant Professor
(Dermatology), Northwestern
University Medical School

12:00 Discussion

Section on Preventive Medicine and Public Health

HERBERT RATNER, CHAIRMAN OAK PARK JOHN B. HALL, SECRETARY CHICAGO

Jade Room #103

9:00 a.m. Panel Discussion: "The Return of Certain Specialty Diseases to the Family Physician — A Modern Public Health and Preventive Medicine Need" Moderator: Herbert Ratner, Oak Park Robert E. Heerens, General Practitioner, Rockford David B. Radner, Phthisiologist, Chicago Norman J. Rose, Public Health, Springfield Jeremiah Stamler, Chronic Diseases, Chicago William H. Whiting, General

11:15 Business session and election of 1962 section officers

Columbia, Mo.

Practitioner, Anna

Philip J. Marco, Psychiatrist,

11:30	Adjournment to view exhibits
12:15 p.m.	Luncheon: Section on Preventive Medicine and Public Health, Illinois Association of Medical
	Health Officers, Illinois
	Academy of Preventive
	Medicine, and Illinois Chapter
	of American Association of
	Public Health Physicians. Open
	to all physicians.
	Speaker: Philip J. Marco,
	Assistant Professor of
	Psychiatry, University of
	Missouri — "Reflections of a
	Psychiatrist on Preventive
	Medicine and Public Health"

Section on Allergy

I. A. FOND, CHAIRMAN				
RAY F. BEERS,	Jr., Secretary	Rockford		

Tuesday, May 15

Louis XVI Room

Louis Avi Room	
9:00 - 9:50 a.m.	"Collagen Disease and Allergy," Leo Criep, Pittsburgh, Penn.
10:00 - 10:20	"The Prevention of the Respiratory Allergic Disease," John Hyde, Oak Park
10:30 - 11:00	Half-hour recess to review exhibits
11:00 - 12:00 noon	Panel — "The Mechanisms of Asthma," Moderator: Max Samter, Chicago "The Allergic Causes of Asthma," Sam Feinberg, Winnetka "The Non-Allergic Causes of Asthma," Milton Mosko, Chicago "Psychiatric Factors of Asthma," George Pollock, Chicago
11:30 - 12:00	Question and Answer period

Section on Radiology

HOMER W. VANLANDINGHAM,	
Chairman	. Rockford
HOWARD C. BURKHEAD,	
Secretary	EVANSTON

Tuesday, May 15

Crystal Room

1:30 p.m. "Radiology of Bone Tumors,"
Charles M. Nice, Jr., Professor
and Chairman, Department of
Radiology, Tulane University
School of Medicine,
New Orleans, Louisiana

Scientific Panels

TUESDAY, MAY 15

Louis XVI Room

Louis XVI Koom	
1:30 - 2:30 p.m.	"Cough," Jerome Head, Evanston, Moderator; Leo Criep, Pittsburgh, Pennsylvania; Gordon Snider, Chicago; Albert H. Andrews, Chicago; Joseph Christian, Chicago
3:00 - 4:00	"Shoulder-Arm Pain," John Fahey, Chicago, Moderator; Arthur A. Rodriquez, Chicago; Clinton Compere, Chicago; Peter Talso, Chicago; Joseph Tarkington, Chicago
4:00 - 5:00	"Post-Operative Problems," Chester Guy, Chicago, Moderator; Donald Oken, Chicago; William Peterson, Andrews Air Force Base; Max Sadove, Chicago; Robert T. Fox, Chicago; Nicholas Cotsonas, Chicago

WEDNESDAY, MAY 16

Section	n on Pediatrics		Schwartz, Chicago; Francis Lederer,
CARL E. SIBILSKY, CHAIRMAN PEORIA			Chicago; Max Sadove, Chicago
ALWIN C. RAMBAR SECRETARY	Highland Park	10:30 - noon	"Cerebral-Vascular Dis- eases," Ford Hick,
Crystal Room			Chicago, Moderator;
9:00 - 9:30 a.m.	"Surgical Emergencies of the Newborn," Harry Richter, Jr., <i>Chicago</i>		Ormand C. Julian, Chicago; Richard Gillis, St. Louis; W. T. Liber- son, Hines; Howard C.
9:30 - 10:00	"Prevention of Obesity in Children," Howell Wright, <i>Professor of</i>		Burkhead, Evanston; Irving Sherman, Chicago
	Pediatrics, University of Chicago	1:30	Oration in Medicine Co-sponsored by Illinois
10:00 - 10:30	View Exhibits		Society of Internal Medicine —
10:30 - 11:15	"The Detection of Hemorrhagic Disease in Children," Irving Schulman, University of Illinois		"The Potential Role of Computers in the Practice of Medicine," William R. Best, University of Illinois
11:15 - noon	"Placental Transmission of Toxic Substances," Alexander Schaffer, Johns Hopkins University	2:00	Camp Memorial Lecture "Newer Ideas on Parathyroid Disease" B. Marden Black, Mayo Clinic
12:30 p.m.	Luncheon Meeting, Illinois Chapter of the American Academy of Pediatrics. Every one	3:15	Oration in Surgery "Vascular Dissemination of Cancer and its Prevention
Gene	attending the section may attend ral Assembly	-	with Evaluation of Chemotherapy" Stuart Roberts, University of Illinois Research Hospital
	ntific Panels	6:00	Social Hour —
Wedn	VESDAY, MAY 16	0.00	Louis XVI Room
Ballroom 9:00 - 10:00 a.m.	"Diseases of Medical Progress," Herbert Ratner, Oak Park,	7:00	Annual Dinner— Ballroom H. Close Hesseltine, Presiding Edward R. Annis, Miami, Florida
	Moderator; Steven		"Patients and Politics"

Section on Physical Medicine and Rehabilitation

LOUIS SCHWARTZ, CHAIRMAN BROADVIEW ARTHUR A. RODRIQUEZ, SECRETARY ... CHICAGO

WEDNESDAY, MAY 16

Gold Room #114

5:00 p.m.

"Modern Trends in Rehabilitation of The Aging," Frank H. Krusen, Minneapolis

THURSDAY, MAY 17

Scientific Panels

Ballroom

9:00 - 10:15 a.m.

"Venous Stasis of the Lower Extremities," Geza de Takats, Chicago, Moderator; Myron H. Kulwin, Champaign; Edward Massie, St. Louis; Lawrence Perlman, Chicago

10:45 - noon

"Hepatitis," Joseph Boggs, Chicago, Moderator; Paul R. Joseph, Atlanta, Georgia; Hyman Zimmerman, Oak Park; T. J. Conley, Park Ridge

Physicians Association of the Department of Mental Health

WERNER TUTEUR, PROGRAM CHAIRMAN . ELGIN

George Bernard Shaw Room

2:00 p.m.

"The Present State of Mental Health in Illinois"

Lt. Governor Samuel H.

Shapiro

"Impotence and Diabetes," Leon M. Beilin, Chicago

"Schizophrenic Aura (Importance of Early

Evaluation)," Igor Leffelholcz
Dubravec, Kankakee State

Hospital, Kankakee

"Children in Illinois Mental Hospitals," by Werner Tuteur, Clinical Director, Elgin State Hospital, Elgin

Discussant, Dr. John Kenward, Chicago

FOUNGE LADIE'S

Guide to Exhibits

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NORTH CLARK STREET

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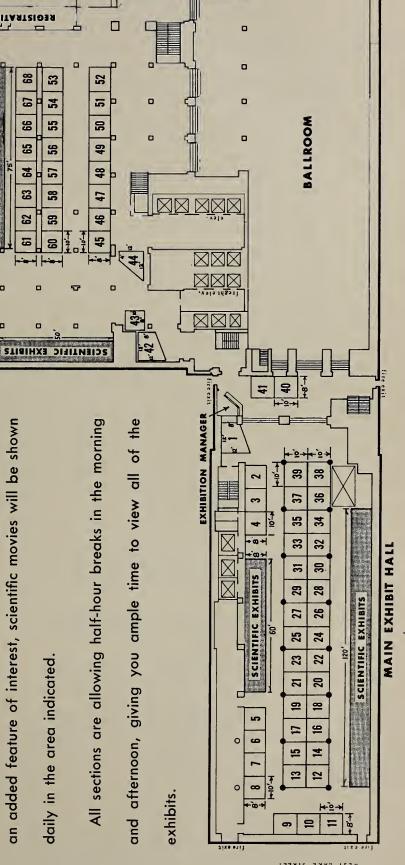
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You are cordially invited to view the many items of medical Scientific as well as technical exhibits are open from 12 noon, Monday, May 14 through 2:00 p.m., Thursday, May 17. As an added feature of interest, scientific movies will be shown interest and related services on display in the Exhibit Areas. daily in the area indicated.



Technical Exhibitors

ВООТН	COMPANY	ВООТН	COMPANY
52	Abbott Laboratories	59	Merck Sharp & Dohme
31	Atomium Corporation	1 <i>7</i>	National Accounts System, Inc.
35	Audio-Digest Foundation	3	Parker, Aleshire & Company
74	Ayerst Laboratories	47	Pfizer Laboratories
42	Blue Shield Illinois Medical Service	70	Physicians & Surgeons Underwriters
60	Borcherdt Company		Corp.
41	Brooks Appliance Co.	67	Playtex Corporation (International Latex Corporation)
4	Cameron Surgical Instruments Co.	63	The Purdue Frederick Company
72	Chattanooga Pharmacal Company	38	Randhurst Shopping Center
54	Chicago Pharmacal Company	2	R. J. Reynolds Tobacco Company
5	Ciba Pharmaceutical Products, Inc.	69	A. H. Robins, Company, Inc.
13	The Coca-Cola Company	39	Roche Laboratories
9-10-11	Daniels Surgical & Medical Supplies	21	J. B. Roerig and Company
55	Desitin Chemical Company	75	Sanborn Company
51	The Dietene Company	56	Sandoz Pharmaceuticals
58	Eisele & Co.	45	W. B. Saunders Company
19	The Emko Company	48	Julius Schmid, Inc.
64	Encyclopedia Americana	68	G. D. Searle & Company
25	Encyclopaedia Britannica	1	7-Up Developers' Assoc. of III.
50	Geigy Pharmaceuticals	34	Spencer, Incorporated
12	Great Books with the Syntopicon	24	E. R. Squibb & Sons
37	Illinois Collectors Association, Inc.	27	Standard Process Labs.
29	Jacuzzi Research, Inc.		(Vitamin Products Co.)
71	The Jobst Institute, Inc.	46	R. J. Strasenburgh
60	J. B. Lippincott Company	7 3	Tru-Eze Manufacturing
43	Lloyd Brothers, Inc.	23	United States Tobacco Co.
40	P. Lorillard Company	76	The Upjohn Company
53	Mead Johnson & Company	62	Vaponefrin Company
44	Medco Products Company	65	Wallace Laboratories
57	Medical Business Consultants	61	Winthrop Laboratories
49	The Medical Protective Co.	8	Woman's Auxiliary

Eli Lilly and Company, manufacturers of pharmaceuticals and biologicals, has provided a grant in lieu of an exhibit this year.

ILLINOIS STATE MEDICAL SOCIETY



122nd Annual Meeting Sherman House Chicago, Illinois May 13-17, 1962

HANDBOOK FOR DELEGATES

Reports of Officers

and

Committees

REPORT OF THE PRESIDENT

The position of president of your Society has become increasingly one of public relations with the medical profession, the ancillary professions, and the public. The time demanded for this work has increased greatly in the past ten years and even in the past two years. Strangely enough, almost every county medical society of any size feels that the president should appear before it in the course of the year of his incumbency. Of course, this is physically impossible, but every effort has been made to fill all such requests in person; when that has been impossible the president elect and the chairman of the Council have been most cooperative about attending those meetings.

In addition to the mcctings of the county medical societies there have been innumerable calls and requests to attend meetings of paramedical groups, such as lawyers, dentists and pharmacists. These are important for they are our allies, and contact must be maintained with them. Another important group are the farmer organizations at both state and local levels. In the past several years the custom of your president attending the annual meeting of state medical societies has developed. This is good, for it maintains contact with these societies, and allows the states to talk over their mutual problems. This year, your president has attended the annual meeting of the state societies of most of the states contiguous to Illinois. These meetings have been most pleasant, and it will be the pleasure of the Illinois State Medical Society to have the president of all of the state medical societies bordering on Illipois as our guests at this meeting.

As an ex-officio member of practically all committees, the number of meetings which I have been expected to attend has exceeded the physical ability of almost any individual. I

have attended as many as I could, although sometimes more than one was scheduled at the same time. Again, the president elect has been most cooperative in assisting, so that the officers of the Society are represented at the meeting. These meetings, along with my being on the Executive and Finance Committee, have made for a very full schedule. In addition to the above, I have attended both meetings of the American Medical Association, as well as a legislative conference at Washington, D. C. The latter was an effort to maintain contact with our legislators in Washington and if possible strengthen our position there. Those of us who attended this meeting felt that our efforts had been worthwhile.

One of the most difficult problems of the past year has revolved around the care of the medically indigent. First the law S.B. 197 had to be modified and passed by the Illinois Legislature. When this was finally accomplished in June, 1961, it had to be implemented by the Illinois Public Aid Commission. This was done by the administrative department, without consultation with the Illinois State Medical Society, and was presented to us as an accomplished fact. This led to some difficulties, most of which were ironed out after consultation with the members of the commission and a special meeting of the House of Delegates. While the present arrangement is not completely satisfactory at this time. your Ad Hoc Committee has requested a meeting with the commission at the completion of a six months' trial run to review the present status.

This meeting will have been held prior to the annual meeting, and a supplemental report can be made at that time.

Your president has attended all but one of the meetings of the Council, the Finance Committee, and the Executive Committee. I have enjoyed the association with all of the officers and the administrative staff of the Society. I wish particularly to thank Dr. Lull, Dr. Piszczek and Mr. Richards for their support the past year. Without such assistance and rapport, it would have been impossible to have done many of the requested jobs. We are fortunate to have such a willing and capable staff.

I wish to express my personal thanks to all the officers and members of the Illinois State Medical Society for their many courtesies and kind assistance in the past two years. It is only by such cooperation that organized medicine can accomplish some of the things we believe in. In times like these, with numerous ideas being proposed in regard to medical care, it is important that medicine present a united front and that we stand firm for those things which we believe are for the good of the public health, even though they are not in accord with the politicians.

Again I express my sincere thanks to you for electing me to this office. I request the same cooperation with my successor that you have given me. I will always be available to assist the Illinois State Medical Society in any manner its members may request.

Edwin S. Hamilton

REPORT OF THE PRESIDENT ELECT

Your president elect has taken part in numerous committee meetings and has visited several component societies together with members of the headquarters' staff. Early in December, I represented the Society at the Conference on Quackery which was jointly sponsored by the American Medical Association and the Health, Education and Welfare Department in Washington, D. C.

The president elect has attended all meetings of the Executive Committee and the Council, but the demands for attendance at meetings

outside of Chicago have fallen largely on the shoulders of the president.

It is hoped that your president elect, when he assumes the office of president, will be able to carry on the duties of that office in the same excellent manner as your present president.

George F. Lull

REPORT OF 1ST VICE PRESIDENT REPORT OF 2ND VICE PRESIDENT Not available at this time

REPORT OF THE SECRETARY-TREASURER

During the past year the administration of the Illinois State Medical Society has taken on added depth in many categories. In addition to the numerous routine and scheduled programs, there have been several major projects which were entirely unanticipated a year ago. As secretary-treasurer I have been in close personal contact with all the members of our executive staff and can report that there has been willing cooperation and eager participation from each member in these multiphased activities. The staff has remained unchanged in the upper echelon, and other personnel changes were primarily readjustments and variations in job assignments, all designed to effect a better work load distribution and more effective utilization of abilities. In my opinion, one of the best examples of the efficiency and the competance of our staff and its organization has been its ability to respond satisfactorily to the several "crash" programs which have demanded immediate action during the past 12 months.

During the year the Regional Administrative Conferences presented in 1961 in each councilor area have again been presented in several districts. The attendance of the entire executive staff at these meetings has been very helpful in explaining the state society's many new activities and establishing a better line of communication with the component societies and their membership. In general, attendance has been better than it was in the previous year.

All members of the staff have given time far beyond the usual office workday to make their services available to the many committees of the state society, various groups and meetings, county medical societies and individual members of the Society. This willingness and dedication to medicine's cause can result only in a better and outstanding Illinois State Medical Society, and it deserves the commendation of not only the members of the House of Delegates but also of the members at large.

House of Delegates Minutes

I have reviewed the complete stenographic minutes of the 1961 annual meeting of the House of Delegates. These were abstracted and, for the first time in the history of the Illinois State Medical Society, published in the June issue of the Journal so that the entire membership could be immediately aware of the actions of the House. The official minutes were published in the September issue of the Journal, and copies will be made available to each member of the 1962 House of Delegates for his decision to accept them as the official minutes of the 1961 annual meeting. An abstract of the minutes of each special meeting of the House of Delegates also was published in the Journal, and copies will also be presented to each member of the House of Delegates. A verbatim transcript of each House of Delegates session is available to any member of the Society upon request to the executive administrator or to the secretary-treasurer.

SECRETARIES' CONFERENCE

The 1961 Secretaries' Conference was held in Springfield on October 8. This meeting proved to be a very valuable means of describing the Society's program to county society secretaries and other officers. It provided a forum for the exchange of common problems and solutions and should be continued as an annual event. With the approval of the Council, a Secretaries' Conference Advisory Committee has been formed and will be responsible for recommendations for this event in the future. Our new "Secretaries' Manual" was distributed for the first time at this meeting. This manual describes the work of each division of our state society and includes samples of the forms used to maintain effective records at the county and state level. The manual is in loose-leaf form and will be updated whenever necessary. Copies of the manual are available at state society headquarters for any county secretary or other officer who is without onc. As recommended by a vote of the Secretaries' Conference, a quarterly county medical society report form has been developed to bring statistical detail and information concerning county medical society activities to the state society office. While there

has not as yet been 100 per cent cooperation in the use of these forms and experience will undoubtedly show the need for some changes, the reports have already been very useful and brought needed information. I not only recommend but urge the continuance of the Secretaries' Conference on an annual basis.

NEW MEMBERS

In the past months a special committee began a membership drive in cooperation with the Circulation and Records Department of the AMA. There are now approximately 3,000 nonmember physicians in our state — 2,700 of whom reside in Cook County. A new membership category which allows physicians in research and teaching to participate in our Society's activities at one-half the regular state society dues will aid us materially in this campaign. A statistical analysis of our present membership follows:

Membership	STATISTICS	
Membership as of		
January 1, 1961		10,168
New members	403	ŕ
Reinstatements	186	
Total added		589
		10.757
Dropped during the y	700#.	10,757
Died during the y	7ear: 191	
Moved from state	191 94	
Resigned	9 4 15	
Nonpayment	267	
Miscellaneous	207 5	
Total dropped	5	E70
rotar dropped		<u>572</u>
Membership as of		
January 1, 1962		10,185
Regular	9,156	
Residents	235	
Service	14	
Emeritus	454	
Retired	295	
Hardship	20	
Interns	11	
Total		10,185

IMPROVEMENTS IN FINANCIAL CONTROLS

The year 1961 was another year of progress in our efforts to improve fiscal responsibility within our office and develop more widespread financial reporting to the entire membership. To this end a new business manager, Mr. Roland I. King, was made responsible for the day-to-day activities of the business office of our Society.

A management letter containing suggestions for improvements in the control and procedures in effect within our business office was submitted with the December 31, 1961, audit. I am happy to report at this time that all of these suggestions have been put into operation. The employment of Mr. King was a fulfillment of one of these suggestions and has served to free the executive administrator and executive assistant for other work, while providing more meaningful financial statements and related financial controls.

1961 BUDGET

Our first budget for the new fiscal period of January 1 to December 31 was revised July 1, 1961, for several reasons. The major factor in this budget revision was the failure of Journal advertising revenues to equal their past performance of about \$11,500 income per month. In 1961 Journal revenues were closer to \$7,500 per month. This decline in advertising income was shared by most other state societies and was due primarily to a cutback in advertising budgets as a reaction to the Washington hearings of the Kefauver Committee into the financial practices of the drug industry. The loss of \$48,000 in anticipated revenue was partially offset by reducing printing costs wherever possible. An extensive campaign to increase Journal advertising has been initiated but will not show benefits until the 1962 year is completed.

The budget was also revised to provide \$5,000 for the 1961 Impartial Medical Testimony program in the Supreme Court of Illinois. This program is a milestone in medical-legal practice within our state, and each of our members can take pride in seeing this important new concept introduced through his state society.

I am happy to report that our total program for 1961 was conducted in such a manner that we were able to add \$22,900 to the Society's reserves. Of this amount \$10,000 has been set aside for possible unanticipated needs during 1962 (such as the special meeting of the House of Delegates on March 17 and 18). The balance will be invested as part of the Society's income-producing reserves against future contingencies.

Investment of Reserves

The investment of current dues income in savings accounts prior to its use in the last portion of the fiscal year, a policy approved by the House of Delegates in 1961, provided our Society with approximately \$10,000 in extra income for our 1961 program.

The long-term investment objectives of both the General Fund reserves and the Benevolence Fund reserves have been given careful consideration during this past year. It is my feeling that the Society has reached a point where the supervision of the investment of these funds should be turned over to professionals trained in this field, with their recommendations subject to the approval of the Finance Committee and the Council. In view of our present relations with the Continental Illinois National Bank of Chicago, our study indicates that the Trust Department of this bank would be the most desirable source for advice and safekeeping of these funds.

It is anticipated that by the time the 1962 House of Delegates convenes, the government bond investments of the Society will have been transferred to the Trust Division of the Continental Illinois National Bank for investment supervision and utlimate investment in government bonds, corporate bonds and common stocks. This action will serve to protect our funds from future loss of purchasing power caused by the chronic inflation in this country since the beginning of World War II.

1961 FINANCIAL STATEMENTS

The following is a condensed financial statement for the benefit of our general membership. Our audited statements for the year ended December 31, 1961, will be provided to each member of the House of Delegates. Copies of

our 1962 budget, as approved by the Council, will be made available to the appropriate reference committee for its consideration and comment.

Jacob E. Reisch

INCOME STATEMENT-GENERAL FUND YEAR ENDED DECEMBER 31, 1961

Income		Expenses	
Membership dues —		Council	\$ 29,626.62
Basic dues — \$80 per member	\$739,783.00	ISMS and AMA Meetings	53,275.53
Less allocations:		Administration	43,010.83
American Medical Education		Business Office	68,132.75
Foundation — \$20 per		Springfield Office and	
member	185,010.00	Legislative Division	84,753.96
Benevolence Fund —		Public Relations and	
\$2 per member	18,496.00*	Field Services Division	98,237.98
Total allocations	203,506.00	Economic Research Division	46,583.73
Net membership dues	536,277.00	Publications and Scientific	
Illinois Medical Journal	91,199.67	Activities Division	42,513.52
Annual meeting exhibits	12,085.00	Illinois Medical Journal	102,870.48
Interest	13,197.19	Nondepartmental	63,459.43
Miscellaneous	2,654.80	Total Expenses	632,464.83
Total Income	\$655,413.66	Excess of Income Over Expenses	\$ 22,948.83

^{°1961} assistance payments totaled \$34,147.98

ILLINOIS STATE MEDICAL SOCIETY POSITION STATEMENT DECEMBER 31, 1961

Assets	Total	General Fund	Benevo- lence Fund	Student Loan Fund	Property Fund
Cash	\$ 91,317.78	75,646.06	14,152.48	1,519.24	
Securities, at cost	238,425.31	93,066.86	140,887.89	4,470.56	
Receivables	10,369.86	10,369.86	140,001.00	4,410.00	
Student loans	84,375.00	10,000.00		84,375.00	
Journal paper inventory, at cost	3,012.56	3,012.56		-,	
Prepayments and advances	5,336.39	5,336.39			
Office furniture and fixtures	56,964.10	ŕ			56,964.00
Total Assets	489,801.00	187,431.73	155,040.37	90,364.80	56,964.10
LIABILITIES AND FUND BALANCES					
Payables	2,234.02	2,234.02			
Accrued expenses	6,243.10	6,243.10			
Deferred income	1,464.00	1,464.00			
Fund balances	479,859.88	177,490.61	155,040.37	90,364.80	56,964.10
TOTAL LIABILITIES AND FUND BALANCES	\$489,801.00	187,431.73	155,040.37	90,364.80	56,964.10

REPORT OF THE COUNCIL CHAIRMAN

The first meeting of the 1961-62 Council was held on Thursday, May 18, 1961, and was followed by meetings in 1961 on June 11, July 16, September 16, October 7, October 28, and November 19. Meetings were also held on January 14 and February 11, 1962. This report is based upon these meetings listed. However, it is planned that meetings will also be held on March 18 and on May 13, prior to the presentation of a supplementary report to the House of Delegates.

ORGANIZATION & APPOINTMENT OF COMMITTEES

At the May 18, 1961 meeting, Dr. Edward A. Piszczek was elected chairman. During the June 11, 1961 meeting the Council reviewed, and with modifications approved the recommendations of the chairman for committee appointments. These were approved for publication with the Constitution & Bylaws as amended at the 1961 annual meeting. Upon recommendation by the executive administrator, Dr. Theodore Van Dellen was reappointed editor of the Journal for the year 1961-1962; and Mr. John

W. Neal was reappointed as special legal counsel for the year 1961-1962.

REPORT REFLECTS COUNCIL ACTIONS

This report is prepared so that it will properly reflect Council actions and recommendations of the Executive Committee presented to the Council. Much of the Council meeting time is given to the review and consideration of committee reports. Because most of those committees report directly to the House of Delegates, there is little effort to include in this report the activities of committees. We recommend your careful reading of all committee reports for therein lies many important activities which have been carefully screened and approved by the Council for implementation.

The following activities of the Council, not ordinarily included in other reports to the House of Delegates, are reported in the order of their introduction to the Council for consideration, including follow-up actions at later dates:

1. Health Care Survey. A recommendation was approved to sponsor, in conjunction with the Department of Public Health, a Health

Care Survey for the State of Illinois. It is anticipated that the Governor will make the necessary appointments of a Citizens' Advisory Committee, as well as an implementing committee by the time of the House of Delegates meeting. Funds for the implementation of the survey will be sought from appropriate foundation sources by the two sponsoring groups. Further details should be available to be included in our supplementary report. A guide for this type of survey is now available from the results of a similar study conducted in the State of California. Copies of the California report will be made available to members of the reference committee should they desire to make a more careful study of what is being contemplated.

- 2. Special Appointments To Represent ISMS. The president, the president elect, the chairman of the Council and other officers give much of their time to representing the Society at official and unofficial functions. There are meetings at which the Society is represented by other members. It is impossible to list all of those who have served in this capacity and therefore we are eliminating the names and duties which they assumed for the Society. The Council minutes are replete with appropriate reports as well as appreciation of the Council for the excellent services of those who have been called upon during the past year.
- 3. Official Speakers Bureau. Based upon the approved recommendation of Dr. H. Close Hesseltine in his presidential report in 1961, there was a special committee appointed by Dr. Edwin Hamilton, president for 1962, to provide a list of official spokesmen of ISMS to be used in areas of controversy. This committee has provided such a list to the executive administrator for designation when requests are received. When and if the executive administrator is unable to decide who shall represent the area of controversy, he is obligated to consult with the Committee for Guidance. During the year this listing of official spokesmen has been used at least 12 times, and has proved to be a valuable aid to the society and to the administrator.
- 4. Administration of IMT. In June 1961 the Supreme Court of Illinois adopted Rule 17-2 which made it possible for Impartial Medical Testimony to be used in all courts of the state, effective September 5, 1961. (See report of Committee on IMT for further details).

With the adoption of Rule 17-2, the Society was requested to demonstrate that this system could be administered in Illinois for the next two years. If successful, the supreme court chief justice will include in his budget for the 1963-65 biennium an amount necessary to continue the program. Thus, the Society was called upon to provide money for administration, and approved the amount of \$5,000 for 1961, and a contingency amount of \$5,000 for 1962. A carryover of \$3,000 from 1961 is now available in addition to the \$5,000 in the current budget for the 1962 administration, which includes the employment of a "medical clerk," consultants, meetings with the judges, liaison with the court administrators, etc.

Furthermore, satisfactory arrangements are now being concluded with foundations to provide funds for the payment of physicians' services. At the close of a two-year period these funds will either be exhausted or returned to the donors. We feel this information should be emphasized in this report because it is concerned with the present and future administrative commitments of the Society, and will require perhaps additional funds for administration until the demonstration period is completed.

5. Local Arrangements for 1962 AMA Meeting. The ISMS is host for the 1962 AMA meeting to be held in Chicago in June 1962. Dr. Walter Bornemeier is chairman of the Local Arrangements Committee, and with approval of the Council, has appointed numerous committees to supervise the hosting responsibilities. The Chicago Medical Society and the Board of Trustees of the AMA have each agreed to assume a third of the financial responsibilities which will ease our financial burden. The host dinner to be held on Monday evening, June 25, 1962, also will be charged for by mutual agreement of all concerned. The other states in which the June meetings of the AMA are scheduled have agreed to make similar arrangements, so that Illinois, which will be host society for every fourth year, will not appear to be neglecting its financial obligations.

As an innovation, the ISMS will sponsor a bowling tournament during the AMA meeting for all interested physicians and their wives, as well as county medical societies. Further details will be made available directly to the entire membership of ISMS, but the House of Delegates should know that the entire cost of this tournament, including prizes, will be undertaken by the Brunswick Company.

The Council has also accepted the responsibility to be the host society for the June 1966 AMA meeting to be held in Chicago. It is hoped that many of the members of ISMS will take advantage of these AMA meetings held so close to their own areas of practice.

6. Establishment of Education & Scientific Foundation. On September 16, 1961, the Council approved an application for the Society to form the Education and Scientific Foundation of the ISMS. These papers have been filed with the necessary state authorities and designate Dr. Edwin S. Hamilton, Dr. Edward A. Piszczek and Dr. Jacob E. Reisch as the incorporators.

This foundation, when approved by the Department of Internal Revenue, will make it possible for the Society to accept funds from individuals, companies and foundations for the purpose of educational and scientific projects. Several projects are now contemplated, and may be implemented during the forthcoming year. One of these is a cooperative scholarship program in conjunction with the Health Improvement Association. Another is a joint project with the Chicago Junior Chamber of Commerce in the follow-up care of narcotic addicts.

The first contribution to this foundation was made by Dr. Joseph Mallory of Mattoon. It is hoped that many members will see fit to make contributions for scientific and educational projects which they may desire to be conducted under the sponsorship of the Society.

- 7. New Scientific Sections. On June 11, 1961, the Council approved the formation of two new sections for the scientific program at the annual meeting. Programs of these sections will be introduced at the 1962 meeting. They are the Section on Physical Medicine and the Section on Neurology & Psychiatry.
- 8. Councilor District Meetings. The Council has continued to encourage its members to hold councilor district meetings. Most councilors have done so, either on a district basis, or in conjunction with single or multiple county medical society meetings. The member education program on the reorganization of the Society's staff, as well as the new services made available under the reorganization, is being con-

tinued. It is quite obvious from inquiries received from county societies that it will require many meetings to be certain that the total membership has had an opportunity to understand what changes have been made in the past 18 months.

In June 1961 the councilors were requested to discuss with their societies the need for passage of the Kerr-Mills bill, SB 197. After passage and thorough discussion at the special meeting of the House of Delegates on October 28, 1961, the councilors were again asked to meet with their counties and explain the implementation of the Kerr-Mills law by the IPAC. In conjunction with this effort, the councilors were to discuss the Society's opposition to the proposed federal King-Anderson bill to provide medical and hospital care for those over age 65 under the social security system. Moreover, as this report is being prepared, the councilors are confronted with a second special session of the House of Delegates to consider the proposed National Blue Shield program for those over age 65.

Thus it can readily be seen that the councilors have been most busy during this year by virtue of the need to arouse the membership to action and to provide many needed facts on the programs of the society. For further details we suggest you review the reports of the individual councilors.

- 9. Workshop Conference with Committee Chairmen. On September 16 the Council met with the chairman, or his representative, of every committee of the Society. A full day of orientation discussions on administrative and workshop sessions on implementation and coordination was most fruitful for all concerned. Committee chairmen were particularly enthusiastic, and as a result, it is the intent of the Council to repeat the conference in the fall of 1962. After that time it will be determined if a similar meeting each year will prove beneficial.
- 10. Appointment of Special Committees. Throughout the year several special committees have been appointed by the chairman at the request of the Council. The full reports of these committees are too lengthy to include in this report, but are available upon request by the Reference Committee:

Cardiac Screening Committee — Chairman,

for April, 1962 411

Dr. John L. Reichert, for the purpose of advising the Director of Public Health and the Governor on further extension of the Cardiac Screening project, such as that carried out in the Chicago area.

Special Ad Hoc Committee on Implementation of the Kerr-Mills bill — Chairman, Dr. Edwin S. Hamilton, with the purpose of meeting with representatives of the IPAC and reaching an appropriate understanding on services to be offered under the law. This committee's responsibilities were enlarged to include the education of the profession on the Kerr-Mills program as an answer to the King-Anderson proposal. It is also to prepare a progress report for the next annual meeting, so that the House of Delegates may make a final decision regarding its desire to continue to cooperate. A special report by this committee will be submitted directly to the House of Delegates.

Special Committee on Laboratory Evaluation — Chairman, Dr. James B. Hartney, for the purpose of establishing the competency of laboratories operating without medical supervision, not licensed by the State Department of Public Health, but approved on a voluntary basis, and not mandatory by legislation. When this committee presents its final report, the Council will report to all concerned its final recommendations.

Secretaries' Conference Advisory Committee — Chairman, Dr. William DeHollander, for the purpose of making recommendations to the secretary-treasurer and executive administrator on the program content of the Secretaries' Conference.

Committee to Study Committees — Chairman, Dr. H. Close Hesseltine, for the purpose of recommending to the Executive Committee what committees should be continued, or combined with other committees. Also to make recommendations to the Constitution & Bylaws Committee regarding the constitutional committees and their purposes and objectives.

11. Amendments to Employee Retirement Plan. Consistent with recommendations of special legal counsel, the Employee Retirement Program has been amended to give all new employees a two-year period in which they will determine whether or not they desire to par-

ticipate. At the end of this time a definite statement from the employee must be filed with the Finance Committee concerning the wishes of the employee.

12. Resolution Commending Dr. Joseph D. Boggs, & Others. At the July 16 Council meeting a resolution was adopted commending Dr. Joseph D. Boggs and his associates for their work in the development of a vaccine for viral hepatitis. Copies of this resolution were presented to Dr. Boggs, his associates, the former and present wardens of the Illinois State Penitentiary, former Governor Stratton, Governor Kerner, and representatives of the Parke, Davis Company.

It was the consensus of the Council that recognition of such a scientific breakthrough was an appropriate action for the Council to take, and will be followed up with similar actions as science progresses in the field of research.

Two other resolutions commending members of the profession were also adopted by the Council; one concerning the past services of Dr. Joseph Compton as chairman of the Advisory Committee to the IPAC, and another concerning the past services of Dr. John Reichert as a member of the Chicago School Board.

13. Special Session of House of Delegates, October 28, 1961. The special meeting of the House of Delegates on October 28, 1961, to consider the Kerr-Mills law implementation was called to allow the county society delegates to determine the policy of whether or not the Society should cooperate with the IPAC on a limited service program, as well as a fee schedule the same as that for regular IPAC recipients.

The abstracts of the minutes of that meeting, consisting of the final Reference Committee report adopted by the House of Delegates, were published in the Journal and will be included in the packet for each delegate to review at the annual meeting. No verbatim transcript of the meeting has been published, but it is available in the headquarters office for the review of any interested member.

14. Recommendation to Governor on Appointment of Director of Department of Health. At the request of the Governor, the Council submitted recommendations to the Governor concerning the successor to Dr. Fatherree, who resigned as director of the Department

of Public Health. The Society was most fortunate to have Dr. Franklin Yoder named as the new director. Dr. Yoder was previously director of the division of environmental health of the AMA, and prior to that, director of public health for the State of Wyoming. We look forward to a close working relationship with Dr. Yoder while he is director in the State of Illinois. He has already demonstrated his ability to work in harmony with our programs, and attends and reports to each meeting of our Council.

15. Association Law Ruled As Ethical. Senate Bill 804 of the last General Assembly in the State of Illinois made it possible for physicians to form associations and thus possibly qualify for certain advantages under a corporate type of structure as set forth in the Kintner court decision. After consideration of the various ramifications, the Council ruled that it would be considered ethical for members of ISMS to form associations under the present law as provided by the state legislature. (For further details see reports of Committee on Medical Economics.)

16. Proposed Judicial Article. The Council has endorsed the changes recommended in the proposed Judicial Article Amendments submitted by a qualified committee on the forthcoming election ballot. The changes are endorsed by the Illinois State Bar Association. The Council believes they deserve the support of the medical profession.

17. Illinois Medical Political Action Committee. The Council secured proper legal opinion and has endorsed the Illinois Medical Political Action Committee and the American Medical Political Action Committee for political education purposes only. It has also approved a plan to solicit voluntary contributions from members of ISMS for the conduct of political education projects by IMPAC and AMPAC.

18. Consultation with Specialists on Fee Schedules. Consistent with a recommendation of the 1961 House of Delegates the Council authorized the chairman to select representatives of the various specialties and have them review fee schedules which are required from time to time. Such representatives are being consulted with respect to the "over 65" National Blue Sheild Program as this report is being prepared. Similar consultations will be used as

fee schedules are submitted for further consideration and review.

19. Caravan of Officers and Staff. Council has approved an experiment to have appropriate officers, committee chairman and staff travel throughout the state on a pre-arranged schedule to contact the general membership. The State Bar Association has found this to be a most productive type of project which takes to its membership the current problems of the association and seeks the opinion of the membership on the solutions thereto.

No formal arrangements have been made at the time of preparation of this report, but the executive administrator is authorized to implement this recommendation at the time most suitable to all concerned.

20. Legal Opinion Concerning Status of Delegates to ISMS. A legal opinion is submitted on the status of a delegate to the House of Delegates of the state society in response to an inquiry from the Peoria County Medical Society. This opinion was accepted by the Executive Committee of the Council on Feb. 10, 1962 (copy of opinion attached as Appendix #1 to this report).

21. Panels for IMT Programs. Periodically the Council considers recommendations pertaining to the names of physicians to be asked to participate on the panels of specialists used under the Impartial Medical Testimony Program (see section 4 of this report). It is important to the success of the program that these listings remain anonymous, and that no one except the executive administrator know at all times the names of all physicians on all panels. The reason for this is simply that the judges, the lawyers, and the physicians involved as participants in the suits, should not know those physicians who are likely to be called upon to be impartial medical witnesses. Only the executive administrator, or his representative, is authorized under the rules to provide the name of the physician who is to review the records and examine the patient.

We trust the House of Delegates will have confidence in the Committee on IMT and in the judgment of the Council in order that these panels may remain semi-confidential. Each year they will be reviewed, whereupon additional names may be added, and some names may be removed.

22. Relations with Osteopaths. Within the past six months, the Council through its executive committee considered three requests for a statement of the present position of ISMS on voluntary association of Doctors of Medicine with Osteopaths. Based upon legal opinion which took into consideration the June 1961 action of the AMA, which made it possible for the California Medical Association to recognize graduates of osteopathic schools, it is the opinion of the Council that any voluntary association by Doctors of Medicine with Osteopaths remains unethical in the State of Illinois. This includes association on staffs of hospitals which are privately operated and not supported through any tax structure. On the other hand, it excludes association with osteopaths on staffs of hospitals which are tax supported, for those institutions are operated by law.

Should the House of Delegates wish to change or amend the position, we suggest consultation with legal counsel prior to presentation of a final recommendation.

23. Position on Proposed National Blue Cross Program. Some inquiries have been received concerning the position of the ISMS on the proposed National Blue Cross Program which was highly publicized during the meeting of the American Hospital Association in Chicago. In consideration of present information available to the Council it is believed advisable that no official position should be taken. The details of the program are no doubt being developed by the AHA and Blue Cross. If they become available between now and the meeting of the House of Delegates, the Council will be prepared to make a recommendation.

24. Legislation on: Veneral Disease Reporting. Based upon discussion by the director of the Department of Public Health, the Council has suggested that the Health Department draft the necessary legislation to adequately reinforce regulations dealing with reporting of venereal disease. When the draft is prepared, it will be presented to the Council for consideration.

25. Resolution on Ethics & Socioeconomic Questions in Licensing Examinations. On January 14, 1962, the Council adopted a recommendation that the Department of Registration & Education consider the inclusion of questions dealing with ethics and proper socioeconomic

practices in the examinations for licensure. This information was communicated to the Department of Registration & Education, to the deans of all medical schools in the state, and to the Committee on Medical Education and Hospitals of the state society.

26. Advisory Committee to Executive Administrator. In order to provide advice from and close liaison with the full- and-part-time executive secretaries of county medical societies, the executive administrator was authorized to select an Advisory Committee to advise him on administrative problems which confront both the state and county societies. Periodic meetings of this committee will assist the executive administrator by providing prompt evaluation of current programs and critical analysis of administrative procedures used by our headquarters staff.

27. Position on Federal Aid to Education. Consistent with the present policy of the House of Delegates against socialization, the Council has adopted a position against federal aid to education. This policy is also the same as that presented by the U. S. Chamber of Commerce and the Illinois Chamber of Commerce, which have so forcefully supported our position with respect to the implementation of the Kerr-Mills program and opposition to the King-Anderson proposal.

We believe this to be a perfectly compatible position with the policies of the House of Delegates, but we suggest that this be confirmed by appropriate reference committee recommendations.

28. County Society Support for ISMS and AMA. On January 14 the Council requested county medical societies to reinforce the position of ISMS and AMA in support of Kerr-Mills implementation and against the King-Anderson proposal. Accusations from political spokesmen assert that organized medicine does not represent the average physician. Many county societies have so indicated their support by resolution with copies to their political representatives. It is hoped that by the time of the annual meeting we will have received resolutions from all societies in Illinois.

29. Legislative Conference January 27, 1962. Official approval was given to conduct a state legislative conference in Chicago on the day following the AMA legislative institute. Each

county society was requested to provide an official representative so that all aspects of the King-Anderson bill might be discussed in order to provide appropriate opposition. For further details see report of Committee on Medical Services.

30. Marion County Resolution on Project Hope. A resolution requesting official support for Project Hope was received by the Council from the Marion County Medical Society. The Council has endorsed this resolution and arranged for it to be introduced as resolution 62-4 at the annual meeting.

31. AMEF Fund Distribution and Special Committee. It has been past policy to have individual members indicate on a card their choice of medical school to which the \$20 dues per member may be allocated. This card has previously been mailed to our members through the deans and alumni associations of the medical schools. Unfortunately this has caused confusion because of duplication of names and the 1961 contribution had to be allocated the same as the 1960 contribution. This was agreed to by the deans of the medical schools, or their representatives.

The per capita dues of \$20 per member during 1962 will be allocated based upon returns from the members on cards addressed to the ISMS. When a member is reported to ISMS as a dues paying member, a card will be mailed to him to indicate to which medical school he desires his \$20 to be sent. A tabulation of these cards will be made at the close of the year and made available to the AMEF for appropriate disbursement to the medical schools. Thus, all members will be assured that their contributions will be given according to their desires.

In compliance with a request from the AMA an appropriate committee designed to implement the program of the American Medical Education and Research Foundation (AMERF) has been appointed. The AMA has combined the previous AMEF with the Research Foundation, and has outlined a program of fund raising which will be made broader in scope than heretofore. Further developments are anticipated in the next few months, and perhaps the committee will have more to report by the time of the annual meeting.

32. Resolution on Legal Status as a Union.

At the special meeting of the House of Delegates October 28, 1961, Dr. Harry Mantz introduced a resolution which was referred to the Council for consideration. The Council requested the Committee on Medical Economics to study the resolution and report back at a later time.

Because there will be a special meeting of the House of Delegates, and at least one other Council meeting before the annual meeting, a supplementary report will be presented by the Council.

This report has been necessarily lengthy because it covers all items of importance presented to the Council not otherwise included in committee reports. If the House of Delegates finds it unduly detailed, we shall appreciate your comment regarding its content.

The Council wishes to extend its appreciation to the delegates, officers of county medical societies, committee members and staff who have contributed so much to the success of this year. We feel that a much finer relationship has been established than has been existent heretofore, and hope that these relationships will be further enhanced during the succeeding years.

E. A. Piszczek, Chairman

APPENDIX I

Edward A. Piszczek, M.D. Chairman of the Council Illinois State Medical Society

Dear Doctor Piszczek:

At the request of Mr. Richards, I have reviewed carefully the material which he forwarded to me under date of December 21, 1961.

The several questions raised by the material referred to are:

- 1. Is a member of the House of Delegates of the Illinois State Medical Society an "officer" of the Illinois State Medical Society? Of his county medical society?
- 2. Granting the moral responsibility of a member of an elective body to attend its meetings, to whom is a member of the House of Delegates of the Illinois State Medical Society legally responsible and accountable in the performance of his duties?
 - 3. May a county medical society, without

violating the Constitution & Bylaws of the Illinois State Medical Society, and without thereby jeopardizing its continuing right to hold a charter from the Illinois State Medical Society, direct its delegates to attend or not attend a given meeting, and/or instruct its delegates as to their conduct and activities in any meeting? To state the question more specifically, does the provision in the Bylaws of the Peoria Medical Society relating to the instruction of its delegates (Chapter VI, Section 5) in any way violate the Constitution & Bylaws of the Illinois State Medical Society?

Other questions present themselves collaterally, but in the interests of brevity, I shall confine myself to those set out above.

In arriving at answers to these questions, I have taken into account not only the language of the pertinent documents, but also the history of the development of medical societies and the traditional relationship between and among the county societies, the state societies and the American Medical Association. From its earliest inception, the House of Medicine has been a "from the bottom up" structure. Therefore, unless we find an express prohibition or reservation of power in a State Society Constitution & Bylaws (as adopted by delegates elected by county medical societies,) we must resolve all reasonable doubts in favor of the autonomy and basic prerogatives of the county society. In a sense, the relationship is not unlike that of the federal and state governments, in which the states reserve to themselves all powers not expressly granted to the central government.

This parallel also exists between the Illinois State Medical Society and the American Medical Association. For many years, to my personal knowledge, state society councils (and in some instances houses of delegates) have "instructed" the society's delegates to the American Medical Association with respect to legislative matters to be considered. I have never heard challenged the legality or propriety of these practices.

It is, then, my best judgment and opinion that:

1. A member of the House of Delegates of the Illinois State Medical Society is not an officer of the Society, because the Constitution & Bylaws of the Society do not so provide. He may or may not be an officer of his county society, depending on the provision which it has made. In the case of the Peoria Medical Society (Bylaws, Chapter III, Section 3) he is so designated. This in no way conflicts with the Constitution & Bylaws of the Illinois State Medical Society. In a general sense, he is an "official" of both organizations, although not necessarily an officer of either.

2. The delegate is obliged to conform to the rules of the convention. If he does not, he is subject to censure or expulsion upon appropriate action by the House of Delegates. (Where not inconsistent, Robert's Rules of Order prevail.) But beyond that, he is responsible and accountable only to the organization which elected him. If the county society membership sees fit to delegate certain functions to its officers and/or council with respect to the "instruction" of delegates, this is its prerogative. and such a delegation does not violate the Constitution & Bylaws of the Illinois State Medical Society. This the Peoria Medical Society has done, and I have seen similar provisions in other county society bylaws.

3. As previously stated, a member of an elective body should not refuse to or be prevented from attending. Unlike the United States Congress and our state legislature, the House of Delegates of the Illinois State Medical Society does not have - under its present Constitution & Bylaws - any way of compelling the attendance of members. However, if a component society were to refuse persistently to permit its delegates to attend, this might well be good cause for the revocation of its charter, which action could be initiated by either the House of Delegates or the Council. It seems most unlikely that county societies would often direct their delegates not to attend either an annual or a called meeting of the House of Delegates. But such a direction unless the same were to interfere substantially with the effective transaction of the business of the House of Delegates of the Illinois State Medical Society — would be within the proper discretion of a county society, since the same would not violate any provision of the present Constitution & Bylaws of the Illinois State Medical Society.

> (Signed) John W. Neal Special Counsel Illinois State Medical Society

PRESIDING OFFICERS ISMS HOUSE OF DELEGATES

The 1962 annual meeting of the House of Delegates of the Illinois State Medical Society will be the first to be presided over by someone other than the president of the Society. Your president has many duties during the convention which includes a very active scientific assembly, an annual dinner, being host to the officers of neighboring state societies, and appearances at many other convention functions. It, therefore, has been considered wise to have two presiding officers whose principal and only duties during the convention will be to preside over the activities of the House of Delegates.

Your presiding officers will attempt to conduct the affairs of the House in accordance with the principles of parliamentary law which assist an assembly in carrying out its purpose. These principles provide orderly ways of determining the will of the majority, yet protect the right of the minority to be heard. In turn, the minority, once the vote has been taken, has the duty of accepting the decision and abiding by the general mandate.

In the House, the place to be heard is in the Reference Committee hearings. Having lost the battle in the Reference Committee is not sufficient reason to re-argue the case before the assembly when the Reference Committee report is being presented. Reasonable belief that the House would disagree with the Reference Committee's recommendations if it knew all of the facts, is good reason to present additional data. That right should be, and will be, protected as long as the discussion is to the point under consideration.

Improvements in the conduct of the affairs of the House have been noticeable for the past few years. The mimeographed packets of resolutions and reports have been a great help. A schoolroom setup where each delegate has a desk is a great convenience in following the proceedings in an orderly manner. Reports published in the handbook make it possible for delegates to be well-informed when they arrive at the meeting.

We hope that the efficiency of the House can continue to improve and the work become more accurate so that policies established can be clear-cut and specific for the information of and implementation by staff at the headquarters office.

W. C. Bornemeier,
Presiding Officer
Harlan English,
Alternate Presiding Officer

REPORT OF THE EXECUTIVE ADMINISTRATOR

The preparation of this report precedes the second special meeting of the House of Delegates scheduled for March 17-18, 1962, during the interim between the regular annual meetings. The first special session to consider the Kerr-Mills bill implementation resolved an important problem for at least a period of six months, subject to a final report by the Ad Hoc Committee to the 1962 House of Delegates. The second special session to consider the National Blue Shield Plan will no doubt be equally, if not more important, because it too may determine the final outcome of national legislation which will seriously affect the future of the private practice of medicine.

I mention these two major meetings because it has been seldom, if ever, that in any one year a state medical society has had two special sessions of its House of Delegates. These have placed a tremendous burden upon the officers and delegates, but I would like to point out that they have also added to the duties of the already very busily occupied staff of the Society. To a degree these special meetings have delayed final follow-through on administrative objectives which I outlined to the House of Delegates in 1960 and 1961. However, we remain ahead of schedule on the reorganization. As a matter of fact, the problems which required the special sessions have advanced certain activities of our staff far beyond the immediate objectives. For example, the Council requested that staff members accompany councilors in their visitations to counties to discuss the Kerr-Mills bill. This made it possible for staff to meet over 50 county medical societies in a few short months. Opportunities to discuss other activities of the Society in public relations, scientific, socioeconomic, and legislative fields were presented and were most welcome.

This was the year for sharpening the staff

Secretary Research Librarian (part-time) and Scientific Activities Director of Publications Supplies Supervisor Assistant Director Equipment & Machines Operator Editor of Journal Assistant Editor (part-time) Assistant Editorial Mail Clerk Special Legal Counsel & Typist (part-time) Executive Committee Services and Economic Assistant Director Director of Medical Secretary Chart Of Staff Organization, as of January 1, 1962 House of Delegates (92 County Medical Societies) President Exec. Asst Research File Clerk & ILLINOIS STATE MEDICAL SOCIETY Bookkeeper Legal Counsel, Journal Editor and 30 employees, including part-time Executive Administrator Chairman of the Business Manager Council Council Research Librarian Receptionist Secretary Assistant Director Media Relations Dir. of Public Field Services Secretary-Treasurer Relations and Assistant Secretary Membership Secretary Services and Springfield Director of Legislative General Counsel Assistant Director Physician Place. Clerk-Typist Secretary Secretary and Regional Office

and its activities to the point where programs of the committees were noticeably effective, and were being communicated to the membership and recognized by the public. Although presented in detail in committee reports, I should like to mention a few of those which I think are important:

- 1. The business office of the Society has been completely reorganized to meet all the recommendations presented by the auditors at the end of the 1960 fiscal year. Refinements on membership records and other services of the business office are being made almost every day. (See the report of the secretary-treasurer for further details).
- 2. A Relative Value Study is being completed for presentation to the House of Delegates. This has been done in less than one year. As far as I know, no state medical society which actually conducted a survey has been able to complete the study in less than two years. Furthermore, the cost has been exceptionally low, primarily because we received the cooperation of the AMA in the IBM statistical analysis of the survey. (See report of Relative Value Committee).
- 3. The Journal has a new look, a new publisher, and two new but not additional, staff members. We anticipate increased advertising for 1962 and more innovations in the Journal to attract reader interest. (See report of Journal Committee).
- 4. A crash program to explain the Kerr-Mills bill and oppose King-Anderson legislation has steadily gained momentum. By the time of the annual meeting every one of the 92 county medical societies should be active in the education of the public on these two pieces of legislation.
- 5. A public relations program, designed to tell medicine's story, has been initiated through channels of communication, i.e., radio, television, newspapers, exhibits, speakers bureau, etc. The effect of these activities should be measurable eventually, but do not expect overnight miracles. Much more needs to be done by state and county societies to improve the public image of the profession. I expect to give more time to this in my oral report to the House of Delegates, but I recommend that every member of the House of Delegates give close attention to the report of the Committee

on Public Relations.

- 6. The Council of the Society has given more and more attention to the development of strong committee activities. A conference and workshop session with committee chairmen and the Council on September 17, 1961, demonstrated that a remarkable improvement can be made in committee programs by the mutual discussion of administrative objectives, adequate provision for budgeting, adequate staff services, and understanding of committee chairmen of the total program of the Society. A continuance of this type of conference has been authorized by the Council, and requested by many committee chairmen who benefitted at the time.
- 7. Strengthening our relationships with county medical societies through services not previously available to them has demonstrated at least in some areas that counties are increasingly aware of their organizational and community responsibilities. To detail these services, as well as to explain the time involved in these efforts, would be difficult and almost endless. But, to say the least, I am remarkably surprised at the increase in tempo on the part of many county societies to the end that medicine be more adequately served at the community level by trained staff persons. For example, Mr. David Meister was employed several years ago as executive secretary of the Peoria County Medical Society. Last year he added the Tazewell County Medical Society to his responsibilities, and this year the McLean County Medical Society has employed his services. A large number of physicians are included in these three counties, and it goes without saying that this will have a beneficial effect upon the administration and public relations of those counties involved.

The Will-Grundy County Medical Society has moved to employ an executive to serve the Aesculapian Society, consisting of the three professions of pharmacy, dentistry and medicine. Community service is the underlying theme to this experiment, and the entire nation will be watching the results, especially those of us intimately associated with medical society administration. This could be the answer to many heretofore unresolved community service responsibilities of these three important healing arts.

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Other county medical societies have under consideration similar arrangements to employ assistance such as in the Rock Island County area. In addition, some societies are reorganizing their present staffs to provide improved services to their members and to the public. Notable among these are the Winnebago County Medical Society and the Chicago Medical Society. Such progress in medical administration is a plus sign and bodes well for the future.

Finally, this has not been an easy year for our new staff. We are now living every day the problems of the profession, and this means that there are administrative difficulties which must be attacked with vision and vigor for the future. Immediate objectives have been accomplished, and now we will find out if we can run the long race. I am pleased to report that I am optimistic in this respect. The committees, the Council and the officers have been encouraging in their comments. Most county medical society officers have been complimentary, but there remain some doubts. I hope the next few years will remove all doubts, and we can build a rapport with the membership which will exceed all previous anticipations.

It is with this challenge in mind that the administrator ends his first twenty months of service, and expectantly looks forward to many more months of service to the organized medical profession in Illinois.

Robert L. Richards

REPORTS OF DISTRICT COUNCILORS

First District

The county medical societies of the First District have, on the whole, enjoyed a rather successful organization year. Two counties, Jo-Davies and Carroll, have gained satisfaction in a partial union of activities. Their small membership produces problems in programming which they have, to a certain extent, overcome by holding joint scientific programs. This does not interfere with their individual representation in the Illinois State Medical Society House of Delegates. Their scheduled meetings and committee organization are equal to most and better than many small societies.

The middle-sized societies operate with good

organization and well-balanced scientific programs. The three large counties have a council type of government. Winnebago maintains a society office with a full-time executive secretary and other full-time secretaries. A well-rounded monthly printed bulletin keeps the membership informed on problems of medical society interest.

Part-time executive secretaries and a secretary's bulletin serve Kane and Lake Counties. The former is divided into three branches, and a well-organized council keeps this society well bound together considering its geographic spread. Branch meetings are frequent, while the less frequent general meetings bring programs of scientific, economic and legislative character.

The societies of the First District have responded well in supporting the state society's legislative and public relations activities. Each has had at least one meeting to acquaint doctors, legislators and others interested in medical problems. The Fifty Year Club has acquired new members, and the councilor has attended to this pleasant duty on several occasions.

On many occasions the members of this group of societies have not seen eye-to-eye with actions of the state society, but like all good organizations, they bow to the will of the majority and have not developed independent action as have some other areas. In several of the counties a weakness is demonstrated in not developing strong auxiliaries. This arm of assistance should not be neglected in these times when all allies are needed. The same is true of the medical assistants' organization.

I wish to thank all of the active members in so many counties for their helpful cooperation which makes the job of a councilor interesting and easier.

Carl E. Clark

Second District

The component county medical societies of the Second Councilor District have not had any outstanding problems during the past year. There are one or two resolutions being prepared in the district for presentation to the House of Delegates at the annual meeting in May, 1962.

The county societies have held their scheduled scientific meetings. Well-qualified men

from some of the larger medical centers in the state have been most cooperative in presenting worthwhile programs. There is increasing activity in the Woman's Auxiliary to the Illinois State Medical Society in medical recruitment and the socioeconomics of medicine.

In November, 1961, a district meeting was held for all of the county societies of the district and for the Woman's Auxiliary Societies of the district. This meeting was highlighted by a panel discussion on "Current Activities of the Illinois State Medical Society," by Mr. Robert L. Richards and headquarters staff; a report from Dr. William McNichols, Jr., Dixon, on the special session of the House of Delegates; and a report from Dr. Dexter Nelson, Princeton, on the Secretaries' Conference held in October, 1961. Mrs. Richard Westland, president of the Woman's Auxiliary to ISMS, gave a very informative talk on "How the Auxiliary Can Help." The after-dinner speaker was Dr. E. A. Piszczek, chairman of the Council of ISMS, who gave a very pertinent talk on government controlled hospitals in Europe.

A talk on Kerr-Mills implementation and utilization has been presented to all of the county societies in the district. These talks have been given by either a member of staff headquarters or your councilor. Following the meetings there has been concerted action to bring the Kerr-Mills legislation into its proper focus. It will be only by individual and concerted action by the members of the medical profession that others can be alerted to the dangers of too much federal control in government with a consequent loss of individual liberty.

Your councilor is an alternate member of the Maternal Welfare Committee, a member of the Committee on Constitution and Bylaws, and a member of the Committee on Medical Service. I have enjoyed my visits to the county medical societies and the friendship and fellowship of the members of the profession. I wish to thank the officers and members of the county societies for the courtesies extended to me. It has been a pleasure to work with the officers and councilors of the Ilinois State Medical Society. I am appreciative of the help and cooperation of the headquarters staff.

Ralph N. Redmond

Third District

The Third Councilor District (Cook County) is represented on the Council by six members of the Chicago Medical Society. These physicians speak for approximately three of every five members of the Illinois State Medical Society. They are active at both the county and the state level.

During 1961-1962, Dr. E. A. Piszczek has carried the responsibility of the chairmanship of the Council of the state society. A complete report as chairman of the Council appears elsewhere in the reports to the House of Delegates.

Dr. John Lester Reichert, until his recent resignation, served as a member of the Board of Education of the City of Chicago; he has confined his activities of the state society's Committee on Child Health. The report of this committee has been published. Dr. Reichert also holds membership on two committees of the Chicago Medical Society.

Dr. Ted LeBoy is a member of the Grievance Committee, the Resolutions Committee, the Advisory Committee to the President of the Board of Health, the Nursing Liaison Committee, and is the secretary of the West Side Branch of the Chicago Medical Society. Over 300 complaints have been processed by the Grievance Committee during the year, and a first-hand knowledge of the problems that beset both patients and physicians results from this activity. At the state society level, Dr. LeBoy is chairman of the Nursing Committee, and because of affiliation at both levels, is able to correlate the work and avoid duplication of effort.

Dr. J. Ernest Breed has been active on the Committee on Legislative Information of the Chicago Medical Society. He has informed the membership about bills before the General Assembly which affect the practice of medicine. Particular emphasis was placed on S.B. 197 to implement the Kerr-Mills law in Illinois. State senators and representatives were invited to the banquet during the annual Clinical Conference. Dr. Breed also assisted in planning the Third District Conference for the Irving Park, North Shore, Northwest, North Suburban and North Side branches of the Chicago Medical Society. The meeting was held at the Edgewater Beach Hotel on February 14, and the

wives of the physician-members were included in the invitation.

Dr. William E. Adams has served the state society as a member of the Finance Committee of the Council and holds membership on several other council committees. He is also the chairman of the Committee on Tuberculosis Control. He was active in planning the Third District meeting for the Jackson Park Branch of the Chicago Medical Society, scheduled on April 19.

Dr. Caesar Portes served the Chicago Medical Society as chairman of its Committee on Cancer, and also as chairman of the state society committee. One of the objectives of these committees is to act jointly and to cooperate with the Advisory Committee on Cancer to the Director of Public Health, appointed by the Governor. The report of the state society Committee on Cancer is published elsewhere. Dr. Portes is also the chairman of the Advisory Committee to the Medical Assistants of the Chicago Medical Society and holds membership on a similar committee for the state society. He is a member of the Public Relations Committee of the Chicago Medical Society, and also of the Committee on Referral Service. As a member of the Executive Committee of the state society council, he has an opportunity to represent Chicago Medical Society physicians and to express their opinions and their thinking at the executive level of the state society.

The format of the report from the Third Councilor District has been altered this year to outline for the members of the House of Delegates, as well as the membership of the Chicago Medical Society, the importance of the positions held by the physicians elected to represent one of the largest county medical societies in this country.

These elected representatives are charged with the responsibility of speaking for over 6,000 physicians in the State of Illinois. When problems arise at the county (or branch) society level, it is the prerogative of the membership to request assistance and information from these councilors.

E. A. PiszczekJ. Ernest BreedJohn Lester ReichertWilliam E. AdamsTed LeBoyCaesar Portes

Fourth District

During the past year the component county societies of this district have continued to be active and have cooperated in the projects sponsored by the state society. The Fourth District is comprised of the counties of Rock Island, Warren, Mercer, Knox, Fulton, McDonough, Henry, Schuyler, Hancock, Stark, Henderson and Peoria.

Your councilor attended all regular and special meetings scheduled by the Council or called by the president, Dr. Hamilton. He attended the Special Meetings of the House of Delegates to consider the implementation of the Kerr-Mills legislation in Illinois. He also attended the fall meeting of the AMA held in Denver.

A Fifty Year Club pin and plaque were presented to Dr. Fred Meixner of Peoria. Dr. Charles Blair and Dr. Frank Winters of Warren County were honored similarly in April.

By decision of the Council the county societies were invited to call a special meeting to explain the Kerr-Mills legislation and implementation in this state so that all concerned understand fully its provisions and the need to make them work. Mr. Roger White of the state administrative office was assigned to this district to help in this program and has been the main speaker at the Warren County and McDonough County meetings. Mr. Walter Oblinger delivered an address to a joint meeting of the Hancock and Henderson counties. At this writing meetings are scheduled in Henry and Knox counties.

The various counties met regularly, and carefully planned scientific programs were held. Some counties meet monthly except for the summer months, while some of the smaller counties meet only every three months.

The Constitutional Committees of the district, namely: Grievance, Third Party Plans, and Ethical Relations committees were not convened since no occasion arose which the component societies could not resolve.

Your councilor wishes to express his appreciation for the cooperation of the societies comprising this district and the individual practitioners with whom he has worked.

Fred C. Endres

Fifth District

The component societies of the Fifth Councilor District are ones which any councilor would be proud to claim. As in past years, they have continued to be active groups whose members are aware of the many problems facing the medical profession today. Because of this their meetings have undergone a progressive metamorphosis during the past few years, whereby several of the customary monthly scientific programs have been supplanted with such subjects as socioeconomic problems, legislative activities, current medical legislation, third party relationships and public relations. In addition, the scope of liaison has been materially broadened by meetings with other professional groups, especially the members of the bar. Both Tazewell and McLean counties are to be commended for their expanded activities in all of these events. Noteworthy in Tazewell County is the early establishment of a Utilization Committee to deal with hospital usage problems.

In Springfield, many interesting activities have taken place. On October 8, a new version of the state society's "Secretaries' Conference" drew county society officers from all over the state to a most profitable meeting. The attendance was the largest in several years, due mainly, no doubt, to the outstanding program prepared. The members attending this meeting had an opportunity to meet and become personally acquainted with the then newly appointed director of the State of Illinois Department of Public Health, Dr. Franklin D. Yoder.

For the eleventh consecutive year, the Illinois State Medical Society exhibit at the Illinois State Fair attracted a large audience. The crowds who visited this booth gave evidence of the interest in and appreciation of the health education provided by this exhibit.

With the ever-expanding activities of the legislative office in Springfield, more and more physicians are finding this facility of benefit to them. Even in "off" legislative years, numerous small meetings and conferences take place here. The many courtesies and helpful assistance of both Mr. Walter Oblinger and Mr. Walter Farrand must be acknowledged.

One outstanding meeting of the Sangamon County Medical Society merits mention. In November this society was host to all of the members of the clergy of Sangamon County at a dinner. The speaker, Granger E. Westburg, D.D., professor of the division of biological sciences and the divinity school of the University of Chicago, is one which each and every county medical society would benefit from hearing.

During the year three Fifty Year Club certificates were presented. Strangely enough, all these were to Sangamon County physicians, Drs. John F. Deal, H. B. Henkel, Sr., and John G. Meyer, Sr.

The Logan County Medical Society presented its usual outstanding Postgraduate Conference in Lincoln on March 15. As in past years, several of the speakers were from neighboring cities, and the meeting always provides excellent opportunities for discussion, especially concerning therapy. Two county societies, Tazewell and McLean, have taken a progressive step during the year by the employment of a part-time executive secretary.

Fortunately, no occasion has arisen which required the services of the District Grievance or Ethical Relations committees. Each of the larger societies in this district have local committees which have handled their problems quite well.

During the past year I have attended all of the Council meetings, the special meetings of the House of Delegates, the AMA annual and clinical meetings, and served on several state society committees.

Each year at this time I seek words to express my appreciation for the excellent cooperation, many kindnesses and willing help of the county society members and officers of this district. There are no adequate words — but the deeds and acts accomplished are adequate proof of the integrity of the physicians of Central Illinois. I sincerely want to thank each of you.

Jacob E. Reisch

Sixth District

The component medical societies of the Sixth District function effectively with an alert and cooperative group of officers. This district continues to furnish interested active members for state society business as committee members

and as delegates to the American Medical Association. Dr. R. C. McGann of Mt. Sterling became eligible and was awarded membership in the Fifty Year Club. Dr. Eugene Moore was honored by his society and received a certificate for his long years of service as its secretary. He also served as chairman of the state-wide Secretaries' Conference.

The Grievance Committee of the district has had no incidents reported for study. The district has an Ethical Relations Committee and a Prepayment Plans Committee. It is gratifying to report that the Woman's Auxiliary to the Adams County Medical Society and the Woman's Auxiliary to the Madison County Medical Society function with enthusiasm. There is hope that another Auxiliary may be formed in the near future.

Several meetings have been held throughout the district to which the doctors and their wives, along with representatives from the legal, dental and pharmacy professions, were invited. These meetings were held to discuss the King-Anderson legislation. Congressman Paul Findley continues to advise us in our fight against socialized medicine. One of the societies was able to obtain TV evening viewing time and Dr. Harry Mantz and Mr. Don Martin participated on a panel on the Kerr-Mills bill. This program received many favorable comments.

Your councilor has attended all the meetings of the Council. He serves as chairman of the Liaison Committee to the Illinois Bar Association and as a member of the Committee on Impartial Medical Testimony and the Finance Committee. Your councilor continues to enjoy his visits to the various societies and wishes to express sincere appreciation for the hospitality and for the many courtesies extended to him. The Sixth District fully appreciates the excellent job being done by Mr. Richards and the staff directors.

Newton DuPuv

Seventh District

The constituent societies in the Seventh District had no major problems since the 1961 report. Consequently there has been no call for meetings of the Ethical Relations, Grievance or Prepayment Plans and Organizations committees.

The Kerr-Mills law implementation by the Illinois Public Aid Commission, under the title of AMIA, has created some dissatisfaction. At the Christian County Medical Society meeting at Pana in December, 1961, your councilor was requested to discuss this subject. This was done with the assistance of Dr. Ralph M. Seaton, delegate from Christian County. A full explanation was given of the decisions made at the special meeting of the House of Delegates of the Illinois State Medical Society October 28, 1961, in Chicago. The discussion was spirited and the criticism very pointed, both pro and con.

One postgraduate conference was held in the district. This was at the new St. Mary's Hospital in Decatur on September 28, 1961. One hundred twenty-five physicians attended the meeting. The program was provided by the Presbyterian-St. Luke's Hospital staff and the University of Illinois College of Medicine faculty. The speakers were Drs. Frederic D. DePeyster, Richard P. Kapp, and Edward B. Beattie, Ir. The evening meeting was addressed by Dr. Walter S. Wiggins, secretary of the AMA Council on Medical Education and Hospitals. Doctor Wiggins' topic was "Licensure and Ethics as a Protection to the Public against Inferior Medical Care." Also present were Dr. George F. Lull, president elect of the state society, and Mr. Robert L. Richards, executive administrator, both of whom spoke on the pressing problems the state society is facing this year.

Two of the new State of Illinois mental care facilities to be built will be located in the Seventh District. The ground has already been broken at Centralia for its area mental health unit. Another unit will be constructed in Decatur in the near future.

Five Fifty Year Club certificates and emblems were presented during the year. On June 21, 1961, Dr. Irving H. Neece, past president of the Illinois State Medical Society, and Dr. R. Z. Sanders, both of Decatur, were awarded certificates and emblems by Dr. Andy Hall, chairman of the Fifty Year Club. Dr. Sylvester F. Henry of Effingham also received his certificate and emblem at this meeting. The awards were made at the Decatur Club before a large group of physicians and friends. Dr. Clarence C. Holmes was awarded his Fifty Year Club certificate and emblem at his residence in Effing-

ham on July 1, 1961, in the presence of Dr. Henry Thompson, president of the Effingham County Medical Society. Another Fifty Year Club award was forwarded to Dr. W. F. Schroeder at Strasburg on October 4, 1961, at his personal request.

My activities for the state society during the past year have been to serve as chairman of the Illinois Delegation to the AMA at the annual and clinical meetings for 1961; to serve on the Committee on Constitution and Bylaws and as councilor for the district. I have attended all the meetings of the Council. I wish to praise the activity of the Woman's Auxiliary in the Seventh District, and I regret that I was unable to attend their annual District Meeting.

In summary, all component societies and auxiliaries have been very active and are being well-informed through the improved communications from the state society headquarters office. The postgraduate meetings and the Fifty Year Club awards make for excellent public relations. Implementation of the Kerr-Mills law by the Illinois Public Aid Commission has aroused criticism in the Seventh District.

Arthur F. Goodyear

Eighth District

The day-to-day medical affairs in the Eighth District have gone well during the past year. There has been a minimum amount of friction between doctors, hospitals, and patients in this area. The outstanding hospital accomplishment during the period was the opening in October, 1960, of the Crawford County Memorial Hospital. In this longstanding top priority area a modern, fireproof, 60 bed institution finally was built. By Jan. 1, 1962, the existing non-fireproof and inadequate hospitals were closed, and the hospital health services are being rendered through the Memorial Hospital.

The Grievance Committee during the year has had only one session, and this resulted satisfactorily to everyone concerned.

In one county there was a considerable amount of political haggling over who should direct the Illinois Public Aid Commission office and services in that county. At this writing this has not been resolved. On a small scale, this certainly points up the problems of total government operation of health services, if such

ever gets to be totally politically oriented.

Largely as a result of stepped-up political pressures to put medicine under the firm control of the bureaucrats and the social security system, fewer and fewer young persons are interested in taking up medicine. Excuses are made about the length of time involved in preparation for medicine. Another common excuse is the desire for early marriage, but careful interrogation reveals that bright young persons don't want to be employees of the federal government. When youngsters from rural areas take such a dim view of the future of medicine it behooves all people in the practice, as well as all citizens, to make every effort to see that governmental control of the profession doesn't come to pass.

With only occasional exceptions, every licensed physician in the Eighth District is a member of his constituent medical society, and the participation of county medical societies in the discussions of medical affairs has been extremely high.

It has been a pleasure to have served medicine in a small way, as a member of the Council, and I am confident that able members will be chosen to act as councilor of the Eighth District in the future.

Harlan English

Ninth District

The councilor of the Ninth District would recommend for the coming year a councilor district meeting, similar to the one held in Harrisburg last year, some time in September or early October. It is hoped that a program of intense public relations could be instituted for the Ninth District through this meeting. It would be necessary that each county society in the district be represented. To do this, it will be necessary for the officers of each county medical society to publicize the district meeting and be sure that their county is represented.

The first district meeting held in this area last year was quite a success. Everyone who attended really enjoyed the meeting, and considerable discussion ensued as to the function of the state medical society. All those present recommended that another such meeting be held.

The activities in the Ninth Councilor District

during this year have been mainly concerned with the problems of medical care for those over 65. There has been some dissent concerning the acceptance of the medical aid to the indigent program as established by the called meeting of the House of Delegates this past year. It is the firm conviction of your councilor that we should cooperate to the best of our ability to make medical aid to the indigent a success. By cooperation it does not necessarily mean accepting the fees which the IPAC offers, but at least these patients could be hospitalized and given care by a doctor through free voluntary service, direct billing of the patient, or billing the IPAC. In the last situation the doctor-patient relationship would not be disturbed with reference to fees.

The nationwide Blue Shield program which was recently instituted and accepted by the American Medical Association appears to be a direct answer to the problems with reference to the King-Anderson Bill and medical care for the aged under Social Security. This program could be instituted nationally, and the fees for the services rendered by the physicians could be established in a bracket that would be satisfactory to the physician. Their service benefits would only apply to those under certain income limits. Above those income limits the program would be an indemnity paid by the Blue Shield. It will be necessary for each county in the district to either accept or reject such a proposal; to participate, at least 51 per cent of the doctors in each county must agree to such a program. This program is certainly recommended by your councilor as one that should be studied very thoroughly and have the wholehearted support of the doctors of this district.

The problem of communication still remains a very serious one. The recent meeting of the officers and delegates of certain counties in the district with reference to the implementation of the medical aid to the indigent program was very poorly represented. There were only four counties out of about thirteen represented at the meeting. It appears that better communications and more interest at the local county society level would produce better results than we have had in the past.

At the Annual Meeting in May, it is the request of your councilor that all delegates from the Ninth District meet on Sunday afternoon

at a time and place to be posted on the bulletin board in the Sherman House. This is for the purpose of talking over things which might come before the House of Delegates and presenting suggestions which you might offer your councilor to facilitate and help delegates, particularly new ones, in their function in the House of Delegates.

Again I wish to thank all the officers and members of the Ninth District for their fine cooperation, even in the face of many highly controversial matters. Keeping in mind that we are all working for the good of the profession and for the purpose of maintaining free enterprise, I hope that our cooperation in this district will continue as in the past. I also wish to thank the staff of the Illinois State Medical Society for their fine cooperation and activity during the past year.

Burtis E. Montgomery

Tenth District

The Tenth District has gone along without too much difficulty as far as the local and district grievance committees are concerned. The old problems still exist of third party communications, third party liabilities and insurance questions which come up between patients and physicians. Third party medicine is really quite a participant in our everyday practice.

Several members of our district are serving on some of the major committees of the Illinois State Medical Society, and I am thankful for their interest in the work of the Society as a whole.

We had a combined meeting with the lower end of the Ninth and the Tenth Districts at Carbondale in October, 1961. The discussion was led by three members of the staff from the Chicago office. Much interest was exhibited at this meeting. Efficiently informed personnel from the staff presented many problems of the membership and explained the situation as it exists on the local, state and national fronts in regard to the problems of the aged, of insurance and of IPAC. They also presented statistical factors in such a way that members can understand more fully the functions of the Society. We believe that the staff of the Society is now being reorganized and as the years pass should prove to be most efficient.

I have submitted the names of delegates who will probably be available for reference work at the coming state society meeting, and I am quite sure that members appointed as submitted by me will do a remarkable and satisfactory job.

I wish to take this opportunity to thank all of the officials of the various county medical societies in the district. I also wish to thank the delegates from my district for their kind consideration and their attentiveness to duty and the men in my district who are members of the statewide committees for their efficient work and the splendid cooperation they have given me and the Society during the past year.

Willard W. Fullerton

Eleventh District

The component medical societies of the Eleventh Councilor District have taken part in all activities which concerned the vital medical problems of the practicing physician as well as the public. Thanks to the efficient help of the staff of the Illinois State Medical Society, all members of the county medical societies were promptly alerted to legislation which would be detrimental to patient and doctor alike. Needless to say, the physicians in this district have responded very well, and the officers of the county medical societies deserve a great deal of credit for their attention to their duties during the past year.

Our District Grievance Committee held a meeting to consider an appeal by two members of the staff of a hospital, who as a matter of principle declined to go along with compulsory staff assessments and alleged that discriminatory action was taken against them. A great deal of testimony was heard both pro and con. The committee expects to render a decision in the near future.

One of the most rewarding duties of a councilor is the presentation of Fifty Year Club certificates. At a combined meeting of the Woman's Auxiliary and the Will-Grundy County Medical Society, Dr. Roy G. Barrick, Dr. Charles L. Garris, and Dr. Earl W. Cauldwell were honored the same evening. At a meeting of the Iroquois County Medical Society in Watseka, Dr. William F. Buckner was pre-

sented with a Fifty Year Club certificate and pin.

Your councilor has attended all the meetings of the Council and served on Tuberculosis and Mental Health Committees.

Again this year the DuPage County Medical Society should be congratulated for its excellent postgraduate medical education meetings in conjunction with neighboring county medical societies. Commendations also are in order for the Will-Grundy County Medical Society on its decision to employ a full-time lay executive secretary.

I wish to take this opportunity to thank the county medical societies and the delegates of the Eleventh Councilor District for their loyal support during the past year.

Bernard Klein

COUNCILOR-AT-LARGE

The councilor-at-large has continued his service in complete fidelity to the Society and its members. The areas of committee work in which he has functioned will be reported under these headings. It is with special pride that your councilor-at-large points out the steady progress and advancement or implementation of the policies of the Illinois State Medical Society as delineated by the House of Delegates. The Council, officers and staff have diligently and energetically fulfilled their obligations. Your state medical society as the fourth largest of the American Medical Association, is expected to be, and has been, a leader.

Another point of pride for our members is the competence of the men whom you have selected as your leaders. Both President Hamilton and President Elect Lull have the attributes and dedication for their offices. Other officers and councilors deserve recognition. Your delegates to the American Medical Association work in unified and coordinated fashion. Our resident trustee, Dr. Hopkins, continues to distinguish himself on behalf of organized medicine. Thus, the pleasure and satisfaction of working with such gentlemen should be obvious.

In spite of some uncertainties of the future, our record should be ample reason to be optimistic. Let us be encouraged by a statement trom David Starr Jordan:

"If the matter is important and you are sure of your ground, never fear to be in the minority. The world turns aside to let any man pass who knows where he is going."

H. Close Hesseltine

ILLINOIS DELEGATES TO AMA

Two meetings of the House of Delegates of the American Medical Association have been held since May, 1961. The June meeting was held in New York with all eleven delegates from the Illinois State Medical Society and six alternates representing the Society in attendance. Dr. Harry F. Dowling of Chicago was the delegate from the section on Experimental Medicine and Therapeutics. Doctor Edward L. Compere of Chicago was the delegate from the section on Orthopedic Surgery, and Dr. Paul H. Holinger was alternate delegate from the section on Laryngology, Otology and Rhinology.

The following delegates served as members on the Reference Committees of the House:

Leo P. A. Sweeney served as chairman of the Reference Committee on Public Health and Occupational Health.

Arthur F. Goodyear was a member of the Reference Committee on Reports of the Board of Trustees.

H. Kenneth Scatliff was a teller at the session.

B. E. Montgomery was a candidate for membership on the Council on Medical Service and was elected by a large majority.

Following the meeting the Board of Trustees selected Percy E. Hopkins to serve as vice chairman. No other Illinois physician was a candidate for any elective office.

Ten resolutions were presented, eight of which were approved by official action of the House. The one resolution which was disapproved dealt with the discontinuance of the scientific portion of the winter meeting. In some cases a substitute resolution was prepared by the Reference Committee, but the intent of the material submitted was carried through. One resolution dealing with private air pilot medical examination was reported back to the House with the recommendation that no action be taken on the resolution.

One item of importance considered by the House of Delegates and the Illinois physicians

present was osteopathy. The AMA issued a statement of policy in regard to working with osteopaths, and a portion reads as follows: "Policy should not be applied individually at the state level according to the facts as they exist. Heretofore this policy has been applied collectively at the national level. The tests now should be, 'does the individual doctor of osteopathy practice osteopathy or does he in fact practice a method of healing founded on a scientific basis.' To date the Illinois State Medical Society has not taken any stand relative to graduates of schools of osteopathy. There are as you know some osteopaths now licensed to practice medicine in all of its branches in the State of Illinois. However, at the present time it still remains unethical to consult with an osteopath in this state."

Some of the other actions taken dealt with polio vaccine, general practice residencies, relations with other health professions, the observance of the principles of medical ethics in regard to surgical assistance, and other important subjects. The House agreed to an increase of \$20 in the annual AMA membership dues to be implemented over a period of two years, \$10 on January 1, 1962, and an additional \$10 on January 1, 1963, which will bring the dues in the American Medical Association to \$45 a year.

The resolution introduced by the Illinois delegation requesting special consideration for physicians in teaching, research or administration was referred to the Committee on Constitution and Bylaws for consideration and report back as soon as possible. This probably will be brought before the House of Delegates at the Chicago meeting in 1962. It is the sincere hope of the Illinois delegation that 50 per cent payment of dues will be permitted to establish special membership status for physicians in teaching, research or administrative work. This action has been taken by the Chicago Medical Society at the locations of the five Illinois medical schools and also by our own House of Delegates to make it possible to contact these men for membership.

At the November meeting in Denver, Illinois had full representation. Dr. Maurice Hoeltgen served as a member of the Reference Committee on Amendments to the Constitution and Bylaws. Dr. Frank H. Fowler was a member of the Reference Committee on Legislation and

Public Relations and Dr. Carl F. Steinhoff served as one of the tellers. The delegates from ISMS introduced three resolutions, the first requesting benefits from women contract surgeons in World War I. This was disapproved by the Reference Committee. The second, dealing with future Physicians' Clubs and Medical Explorer Posts which originated in Adams County, was approved. This material was reproduced and sent to all officers and councilors, all county medical society secretaries and to the chairman of Recruitment Programs of the Woman's Auxiliary to the ISMS. The third resolution, which acted upon the House without referrals to a Reference Committee, was a tribute to the memory of Dr. Andy Hall.

At this meeting Dr. Edwin S. Hamilton as president of the ISMS presented a check for \$185,000 to the American Medical Education Foundation. Mrs. Harlan English of Danville administered as president of the Women's Auxiliary to the American Medical Association. She addressed the House of Delegates in regular session on Monday, November 27, outlining in detail the aims and aspirations of the members of the Auxiliary to cooperate and assist their physician-husbands in constructive and sustained activities.

Future American Medical Association meetings are as follows:

Annual Meetings

1962 — Chicago, June 24-29

1963 — Atlantic City, June 16-21

1964 — San Francisco, June 21-26

1965 — New York, June 20-25

Clinical Meetings

1962 — Los Angeles, November 25-29

1963 — Portland, Oregon, December 1-4

1964 — Miami Beach, Nov. 29-December 3

As in the past, breakfast meetings of the delegates, alternate delegates and all members of staff in attendance at both the New York and the Denver meetings were held each day. Dr. Arthur F. Goodyear served the delegation as chairman and Dr. Leo Sweeney as secretary. They were elected at the close of the Clinical Session in Washington, D. C. last year. At the breakfast meetings, the activities for that day were outlined and definite assignments given to

the men for attendance at Reference Committee meetings and contact with special groups. On the opening day of both the New York and Denver meetings the Illinois State Medical Society was host at a luncheon for all AMA officers, Council chairmen and members of the House of Delegates. The alternate delegates and all state society officers in attendance at the AMA sessions were also included.

It is the opinion of the members of the delegation that having the officers of the Illinois State Medical Society and the alternate delegates, as well as members of staff present at meetings of the AMA House, has been of material assistance in establishing prestige for Illinois medicine.

Arthur F. Goodyear,
Chairman
Leo P. A. Sweeney,
Secretary
Harlan English
Frank H. Fowler
Walter Bornemeier

M. M. Hoeltgen B. E. Montgomery H. Kenneth Scatliff Carl F. Steinhoff Harry Mantz E. W. Cannady

INTERPROFESSIONAL COUNCIL COMMITTEE

The medical representatives to the Interprofessional Council Committee have met monthly with the other members of the Council. A medical representative has been active on the Annual Meeting, Legislation, Liaison, Nominations and Publications committees.

On May 23, 1961, the Interprofessional Council held its annual dinner and presented its Distinguished Service Award to Dr. Frederick H. Falls. The award is given to those who have contributed substantially to the health and welfare of the citizens of the State of Illinois. The 1962 annual meeting will be held on April 28. The person to receive the award has not been chosen at the time of preparing this report.

The Legislative Committee has been relatively inactive this year, primarily because the state general assembly has not been in session. However, there have been reports rendered and support requested concerning federal legislation.

The Publications Committee has published *Comments* from each of the groups represented on the Council. This is a mimeographed newsletter distributed to the various officers of the

societies and their representatives. Copies also have been made available to other state societies.

The principal activity of your representatives during the year has been the exploration of the possible development of an Illinois Association of the Professions. This exploration was authorized by the 1961 House of Delegates.

A meeting on January 18, 1962, with the Executive Director of the Michigan Association of the Professions proved to be very helpful. Unofficial and personal inquiries to several members of prospective groups have proven their interest. It is the intent of the committee to officially approach representative officers of the associations of Architecture, Dentistry, Engineering, Veterinary Medicine, Law, and Pharmacy in order to find out if they would be interested in forming an association of the professions in Illinois. Perhaps by the time of the annual meeting a supplementary report will be available concerning this aspect of our report.

Unfortunately, during this year it was necessary for Dr. Roland Cross to resign as a member of our committee due to a conflict in meeting dates which could not be avoided. With this exception, the committee has been represented at each meeting of the Council during the year. George B. Callahan, James D. Majarakis Chairman William K. Ford

A. J. Brislen

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

This committee serves more or less on a standby basis, ready to assist the Woman's Auxiliary in an advisory capacity if needed and requested. The entire committee met with the officers and board members of the Auxiliary on October 16, 1961, at Blue Shield headquarters.

On November 10, 1961, the chairman of the committee took part, together with Mrs. Wendell L. Roller, president elect of the Auxiliary, in a "Bizarre Bazaar" sponsored by the auxiliaries of the Rock Island and Henry County Medical Societies. Over \$800 was raised at this Bazaar for the American Medical Education Foundation.

We are all very proud of the excellent work

the Auxiliary to the Illinois State Medical Society is doing in many fields, and especially the activities in connection with current legislative affairs.

George F. Lull,

Chairman

Edwin S. Hamilton

E. A. Piszczek

Ex-officio:
Robert L. Richards

WOMAN'S AUXILIARY: PRESIDENT'S REPORT

At the time of this report we are about twothirds of the way through our Auxiliary business year. Much has been done, but the race is far from over. Many times the last lap of a race determines the value of the team. Ours is a team. A relay team. Each member, each branch, each county and each state play a part on our team, and we are now ready for our "anchor man" to get in the race.

Here, however, the analogy ends. Unlike a relay team that merely cheers the last man on, our team, the whole team, now gets in the race itself and every member is called upon to perform at the utmost of his abilities. We are in the final lap, and the result of the entire year of work hangs in the outcome of this last four months. Our position at this point is like having an astronaut out in space. If we don't get him down safely, the entire project is a failure.

At this point the reports have been favorable, and everything is going according to plan. Eleven districts have held their meetings under the direction of the eleven district councilors. It was my good fortune as president to attend all these fine meetings and witness the progress firsthand.

At all of these meetings our priority projects of membership, legislation and AMEF received good publicity and support. At this point, we can announce that we have experienced an increase in our members-at-large with very good possibilities of organizing another county to our team. It is the hope of this president that this organization will take place this year.

Legislation, our number two item in rank, has also been bolstered with the WHAM project. Women Help American Medicine has been vigorously and generously received as the main arm of support for our cause of the free practice of medicine. At our initial meeting in Illinois on January 27, 1962, over seventy ladies

attended and were inspired with new enthusiasm. Here again the race is just starting, and this one has to go all the way across the country. We must gain support of the people and rededicate them to the cause that has made our country great. Through the last two decades we have changed the attitude of the people from that of a government run by the people to a government run for the people. We must all disperse the truth that a government that can supply all the wants of the people is also a government that is large enough to take all that the people have.

Along the same lines of governmental control our AMEF program comes into the front. If we don't support the schools that have made our system of medicine possible, someone else will. This country needs doctors. This country will have doctors. All that is left is to determine who will help prepare them. If the government has to step in, socialized medicine is sure to follow. If we support them and help them expand their facilities our doctors will be able to keep control of the curriculum and insure the quality of our graduates in addition to preserving the American way of medicine that has proven itself to be the best in the world. The collections for AMEF are coming in very well, but we have so far to go. Let's not run out of breath now. Keep up the race. Our adversary, the growing conception of government control, has a head start, but we are gaining. We may be the "underdog" but we can win; support is what we need to do so.

These three priority projects, as I have reported, are doing well and according to plan. They are the front runners of our relay team, but there is a lot more behind their performance. Community service, recruitment, publicity, civil defense, safety and every other phase of our work bolsters and supports our priority projects.

It has been my privilege to observe some of the work that has been done within these committees these past months. In the field of recruitment, I was happy to hear that many counties give scholarships to assist the future nurses. Other groups have formed Allied Medical Career Clubs and have found them worthwhile and successful.

I have attended many meetings where the program of the day illustrated and expanded

our views concerning civil defense, community service and safety. I am happy to report that many excellent programs have been organized throughout the state, and that our publicity has been increased.

In line with publicity, the Woman's Auxiliary to the Illinois State Medical Society has a section entitled "Illinois Auxiliary News" which is now a regular part of the well-known *Pulse*. It is our goal and purpose that this new section will attract many more new members and reactivate some of us who have taken a back seat.

On our team there can be no one watching from the stands. We are all on the same squad. Every member, committee chairman, and elected officer from the newest member to the president will be needed, and we still need more. We are a multiple purpose organization, and yet we have but one goal: support for our husbands' medical practice and the improvement of health. Our entire team is not even in the big race and never will be. Our husbands have to carry the ball, but with our help they perhaps will have a better track on which to run and a bigger crowd cheering them on to victory. They cannot run alone. We must run along at the side and spread the word across the land. This year there is only one more lap to go. Let us all get in the race to win.

Mrs. Richard E. Westland

COMMITTEE ON BENEVOLENCE

For the first time since its inception some twenty years ago, the Benevolence Committee is faced during 1962 with the possibility that a portion of the \$140,000 in government bonds invested in the the name of the committee will have to be used for committee expenses during the year.

The monthly expenses of the committee continue to run about \$3,000. There are between 43 and 45 beneficiaries divided between Cook County and downstate as follows:

Chicago, 4 or 5 physicians and 10 or 12 widows with a monthly payment totaling approximately \$1,100.

Downstate, 6 to 8 physicians and 20 to 23 widows with a total monthly payment of approximately \$1,900.

At the present time \$2 per capita for each of the 9,200 dues-paying members is deposited to the account of the Benevolence Committee. This totals \$18,400 annually. Gifts from the Auxiliary average \$5,000 a year, which they secure through dues and donations. This gives the committee \$23,400, to which may be added the interest from the \$140,000 in bonds, resulting in an annual income of \$27,600. This is \$8,400 short of the actual expenses for the year.

After the committee met on September 6, 1961, the following suggestions were presented to the Council:

- 1. That the Council raise the amount allocated to the committee to \$3, \$4, or \$5 annually per member, which would change the financial picture according to the figure involved.
- 2. That all investments held in the name of the committee be reviewed and kept current to provide the maximum return to the committee.
- 3. That the committee conduct a sustained drive for contributions to the fund in any acceptable manner, and that tax exemption be established by our legal counsel if possible.
- 4. That the committee continue to operate on the \$2 allocation, and ask that the annual deficit be paid out of the general funds of the Society.

All matters dealing with finances are referred to the Finance Committee for recommendations to the Council prior to final action. The Finance Committee considered the report of the committee and made the following recommendation which was approved by the Council on January 14, 1962:

"Because present expenditures are exceeding income received from the \$2 each per duespaying member, there has been an annual deficit of about \$8,000 for this committee during recent years. The Finance Committee of the state society does not recommend that any money from the general funds be transferred to make up this deficit inasmuch as there is currently a reserve in the Benevolence account exceeding \$140,000 in government bonds and savings. The Finance Committee also recommends that the Benevolence Committee be permitted to make use of the Retail Credit Corporation to investigate those cases agreed upon by the committee and Mr. Richards as executive administrator."

This last action was taken so that the committee can be reasonably sure that those recip-

ients already on our Benevolence list are receiving money which is actually needed, and determine whether or not the amounts furnished are adequate.

The committee also established some general policies:

- 1. No committee funds are to be expended for funeral expenses.
- 2. No committee payments are to be made to individuals on OAA or other governmental programs of similar nature.
- 3. Occasional gifts to individuals on OAA are to be discouraged.
- 4. All recipients must have applications filled in by the individual himself or his representative.
- 5. All recipients must personally desire the assistance offered.
- 6. The circumstances of each recipient must be reviewed by a member of the Society, a member of the Auxiliary, a county medical society officer, etc., so that an adequate appraisal can be made. This personal investigation is desirable whenever possible before any committee action is taken.
- 7. Members of the headquarters staff are to be furnished with a breakdown of recipients by counties so that personal contact can be made whenever a member of the staff is in that area.
- 8. All cases are to be reviewed annually with personal investigations whenever possible. A questionnaire is to be developed to keep information current and accurate.
- 9. The power of attorney (or a copy) should be on file in all cases where this is indicated.

Some of these recommendations have been followed since the committee was organized; others are new and constructive. The committee solicits assistance and suggestions from the House of Delegates relative to future procedures and future activities.

The committee would like authorization to investigate sponsoring an approved nursing home which could be recommended to the families of these elderly physicians and/or their widows. This would not involve either the purchase or the financing of any nursing home, but would mean that the Society would recommend one home when consulted. This procedure might result in the development of a home where the patients have a similar background and similar interests. It is the understanding of

the committee that New York has proceeded in this manner, and information from that state may be of assistance to the committee.

The committee wishes to express its sincere appreciation to the members of the headquarters staff, and in particular Mrs. Frances Zimmer, for the excellent cooperation given during the past year. Without this assistance the committee would find its work extremely difficult. The committee also feels that guidance from the Finance Committee, the Council and the House of Delegates is essential for the successful operation of this important Society activity.

Keith H. Frankhauser, *Chairman* Irving H. Neece F. M. Nicholson

MEMBERSHIP COMMITTEE

The Committee on Membership has the privilege, through the endorsement of the Council of the Illinois State Medical Society, to work with the American Medical Association in the special membership drive in the State of Illinois conducted as a pilot study. It is estimated that there are some 3,000 licensed physicians in this state who are not members of organized medicine. About 300 of them are from the downstate area, while 2,700 are in Cook County.

A major problem for the committee and the headquarters staff has been a deficiency in information. After such screening as can be effected by the committee has been completed, the names will be given to the secretaries of the respective counties. The Membership Committee of the Chicago Medical Society has requested our cooperation.

ISMS MEMBERSHIP AS OF DECEMBER 31, 1961

	CMS	Downstate	Total
Regular	5,615	3,541	9,156
Residents	217	18	235
Service	13	1	14
Emeritus	222	232	454
Retired	204	91	295
Hardship	15	5	20
Interns	11	0	11
	6,297	3,888	10,185

Thus, each new member is important to us

for strength as an organization, beneficial to himself and helpful in the budget. For instance, 1,000 full dues-paying members would add \$58,000 to the ISMS budget (the \$20 for AMERF and the \$2 for Benevolence is over and above this amount). Moreover, an increase in memberships is equally desirable for the county societies.

All the downstate IBM cards from the American Medical Association have been mailed to the county society secretaries, and interesting information relative to the nonmembers is being received in the headquarters office.

In view of the fact that the five medical schools were contacted as to the membership of their faculty, it is well to point out that actually the school faculties (percentage-wise) are better off than the medical population as a whole in Cook County.

The fewer licensed physicians there are outside of organized medicine, the more united we will be and the smaller will be the vote of discontent arising from lack of knowledge about the thinking of organized medicine.

H. Close Hesseltine,
Chairman
Walter C. Bornemeier
Fred C. Endres
Wright Adams
Granville Bennett
John F. Sheehan
John J. Sheinin
Richard H. Young

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION

The American Medical Education Foundation was established in 1951 for the purpose of providing financial assistance to medical schools. In 1953 the Illinois State Medical Society, by action of the House of Delegates, included a \$20 per capita donation to the AMEF through our dues structure. Since that time the total from our dues has amounted to \$1,576,620. This total includes \$185,000 presented to the AMEF in Denver at the Clinical Session, November, 1961.

Notice has been sent through the press and through the American Medical Association that on January 1, 1962, the programs of the American Medical Education Foundation and the American Medical Research Foundation are to be consolidated within the framework of a single foundation. However, there will be no change in the support to medical schools

through the dues structure of the Illinois State Medical Society. Each individual physician has the privilege of designating to which school this amount from his dues shall be allocated.

On January 11, 1962, Mr. Richards as the executive administrator and Mrs. Frances Zimmer as the staff member assigned for AMEF activity met at the American Medical Association headquarters with the deans of the five medical schools in Cook County or their representatives, and with representatives from the business office and the Membership and Records Department of the American Medical Association. Mr. Russell Clark, director of the Business Division of the AMA, presided at the meeting. The method by which the individual physician in Illinois could designate the school to which he wished his \$20 allocated was the main topic for discussion. It was the feeling that neither the American Medical Association nor the AMA-ERF should deal directly with the individual members and that it was the responsibility of the Illinois State Medical Society to handle this problem within the framework of the state society. Therefore, official cards were mailed by ISMS headquarters to all dues-paying members, and each physician was asked to designate the school of his choice and return the card to ISMS headquarters. When the total amount is presented to the AMA-ERF for 1962, the official list will accompany the check. The Illinois State Medical Society Office will keep the deans of the medical schools informed annually of those physicians who list each school to receive their \$20.

The method by which the school designation can be made in the future in a more simple manner also was discussed. It is hoped that this can be handled at the county level at the time the individual physician pays his county, state, and AMA dues. Then this information will be a part of the county medical society report to the Illinois State Mcdical Society headquarters when remittances are prepared.

The deans of the five schools agreed to continue to contact the alumni, and encourage them to mark their \$20 for each particular school, but they also agreed to discontinue sending individual return postal cards so that a duplication of effort in this area will not result in the future.

At the present time there are nine states

where donations are an automatic part of their dues structure. Among the states are Indiana, Texas, New Jersey, California, Arizona, Nevada, and Colorado. Illinois was the first state to handle the contributions in this manner, and as a result has lead in this field of equalized contributions to medical education. It is sincerely hoped that all members of the state society will continue to give to AMA-ERF individually, over and above the \$20 allocated from the annual dues structure.

Arkell M. Vaughn, Chairman for Illinois

CONSTITUTION AND BYLAWS

The Committee on Constitution and Bylaws has met on several occasions during the past year. It has considered changes in the Constitution and Bylaws (1) referred by the 1961 House of Delegates, (2) suggested by the administrative office of the society, and (3) embodied in resolutions or letters from component societies or individual members. It has also undertaken a general revision of the entire document.

The need for the last action appeared to the committee to be required (1) to reorganize the document into a constitution in which broad principles were delineated, and into bylaws in which the principles were detailed and procedures were specified, and (2) to place related material in juxtaposition.

In the course of the year a report of progress was made at intervals to the Council. Although no formal vote of the members of the committee on these proposed revisions and recommendations has been taken, the Council directed the committee to include in this report several of the contemplated recommendations because of the controversial status of some of the material.

It is anticipated that the following will be proposed:

- 1. That the name of the Society be changed to "The Illinois Medical Association."
- 2. That the requirement of citizenship for membership be removed.
- 3. That the secretary-treasurer of the Society be elected annually by the Council from its membership.
- 4. That the titles of "presiding officer" and "assistant presiding officer" be changed to

"speaker" and "vice speaker."

5. That the speaker (and the vice speaker) be authorized to appoint, with the advice of the president and the president elect, the reference committees for the House of Delegates.

6. That the term "annual convention" be substituted for "annual meeting" and "session" for the various "meetings" of the House of Delegates, and that the various sessions together constitute the "Annual Meeting of the House

of Delegates."

A draft contrasting the present document and the proposed document will be prepared for each member of the House of Delegates in time for the first session of the House.

William H.
Schowengerdt,
Chairman
Walter C. Bornemeier,
Vice-chairman

Andrew J. Brislen Arthur F. Goodyear Fred C. Endres Ralph N. Redmond

Committees Assigned to Director of Medical Services and Economic Research

PREPAYMENT PLANS
AND ORGANIZATIONS
Report not available at this time

COMMITTEE ON AGING

During the past year two meetings of the committee were held, one during the week of the annual meeting of the Illinois State Medical Society and the second on September 17. Smaller groups of committee members have met on several occasions to discuss special problems.

Doctors H. Close Hesseltine and Henry M. Wilson represented the committee and the Illinois State Medical Society at the First Regional Workshop on Home Care held in Chicago, May 24-26, 1961. As a result of this conference and upon the recommendation of the Committee on Aging, the Council authorized the committee to study and support the expansion and creation of additional home care programs in Illinois. A subcommittee of the Committee on Aging has been appointed for home care programs under the chairmanship of Doctor Wilson. The Committee on Aging of the Women's Auxiliary of the Illinois State Medical Society is serving as consultant to this committee.

The director of Services for the Aging of the Illinois Public Aid Commission invited the Committee on Aging to act as co-sponsor to a four-year pilot program of active research to demonstrate methods of approaching more adequate psychiatric services to older people, especially those in nursing homes. With approval of

the Council, the Committee on Aging accepted the invitation and will name a representative to the Advisory Committee for the Psychiatric Extension Program.

Doctors Joseph Mallory, Henry T. Ricketts, and Edward W. Cannady represent the Committee on Aging in the Illinois Joint Council to Improve the Health Care of the Aged. Doctor Edwin Hamilton and Mr. Roger White serve as ex-officiary members. The representatives attended two meetings of the Illinois Joint Council to improve the Health Care of the Aged and also the National Conference of the Joint Council to Improve the Health Care of the Aged held in Chicago December 15-16. At present, the Illinois Joint Council to Improve the Health Care of the Aged is primarily concerned with a hospital-nursing home affiliation plan and accreditation of nursing homes. Regional meetings are planned for the study of hospital and nursing home relationships.

The number one project of the committee during the past year has been the Care of the Stroke Patient. This program has received national recognition. A subcommittee on Care of the Stroke Patient is under the chairmanship of Doctor Edward Gordon. Three programs have been held. At the time of this writing there are tentative plans for the Committee on Aging to co-sponsor an additional program in Murphysboro in April. The programs have included demonstration projects for hospitals and nursing home personnel and all others interested in the care of the stroke patient. The first program was held in St. Clair County, in Sep-

tember. More than 150 nurses and other persons attended each of the two sessions held at hospitals in East St. Louis and Belleville. More than 90 physicians attended an evening Care of the Stroke Patient program which included diagnostic problems. A similar program was held in Mattoon in November. Approximately 120 nurses and 28 physicians were reached. The third program was held in the two hospitals in Springfield in December, but did not include an evening program for physicians. Approximately 157 nurses attended. Members of the eommittee in the above areas were in charge of local arrangements.

One of the objectives in the stroke program is to secure the appointment of a rehabilitation nurse in the hospital. Funds are made available through the Illinois Department of Public Health for a short specialized training course in rehabilitation nursing at one of several teaching centers throughout the country.

Further efforts will be made to extend the stroke program to other parts of the state. However, it is recognized that personnel will not be available to eonduct the program in all areas. In an attempt to reach the many hospital staffs and personnel in the state, a film will be made with the cooperation and financial support of the Illinois Department of Public Health. This film will emphasize minimizing disability from strokes by early preventative care. Several films are available on the care of the stroke patient but none with particular emphasis on early care. It is expected that this film will be of national interest.

Several counties are conducting active programs in the field of aging. However, more emphasis should be placed upon expanding these programs on a local level. The committee hopes to encourage such expansion.

The committee again desires to acknowledge the invaluable services of Mr. Roger White, Director of Medical Services and Economic Research of the Illinois State Medical Society as consultant and for providing staff services.

Eward W. Cannady,
Chairman
Henry T. Ricketts
Thomas T. Tourlentes
Edward E. Gordon
P. V. Dilts
Joseph Mallory

Caesar Portes
Roger F. Sondag
Henry M. Wilson
Warren D. Tuttle
Ernest G. McEwen
H. Close Hesseltine

FEDERAL MEDICAL SERVICE
Report not available at this time

LIAISON, ILLINOIS HOSPITAL ASSOCIATION

Liaison with the Illinois Hospital Association has continued most satisfactorily at quarterly intervals. The third annual Joint Conference of Hospital Trustees, Administrators and Chiefs of Staff sponsored by the Illinois State Medical Society and the Illinois Hospital Association on "Hospital Utilization" was held at the Hotel Leland in Springfield on April 19, 1961. As an outcome of this meeting a joint statement has been formulated and submitted for approval urging all hospitals in Illinois to establish an active committee composed of medical staff members and administrator to responsibly review and control all factors influencing hospital utilization.

The fourth annual Joint Conference has been scheduled for April 12, 1962, at the Sherman House in Chicago. Nursing directors will also be invited to this year's conference to share in the discussion of "better inpatient care". The actual program is being planned by a joint subcommittee of the Illinois State Medical Society and the Illinois Hospital Association.

John J. Procknow, H.

Chairman No
Robert E. Dunlevy Jar

H. J. Shaughnessy Noel G. Shaw James W. Sours

IPAC ADVISORY COMMITTEE

The State Medical Advisory Committee to the Illinois Public Aid Commission has held six regular business meetings since the last annual report to the House of Delegates of the Illinois State Medical Society in May, 1961. Two new members, one from Cook County and one from downstate, were appointed in June 1961, and Mr. Roger N. White, a staff director of the Illinois State Medical Society, serves as an exofficio member and attends all meetings. When Dr. Joseph W. Compton, East St. Louis, who served as a member of the committee from 1953 to 1960 and as chairman from 1959 to 1961, resigned in June, 1961, the present chairman was appointed to succeed him. At the same

time Dr. William H. Whiting, Anna, was appointed to serve as co-chairman. All meetings of the committee have been well attended by official and ex-officio members.

The year 1961 was also one of change in members and officers of the Illinois Public Aid Commission. Several new members were appointed in 1961 to fill vacancies. Mr. Virgil C. Martin, president and director of Carson, Pirie, Scott and Company, named as a member by Governor Otto Kerner in June, was elected chairman by the commission at its meeting in July. The committee has been informed that the Illinois Public Aid Commission is faced with fiscal problems for the year 1962 as the budget request for the public assistance programs for the 1961-1962 biennium was reduced by \$106 million. A deficiency appropriation will be required, but the cash position of the State of Illinois is precarious and the state's fiscal operation must be contained within foreseeable income. At a cabinet meeting held on December 19, 1961, the governor outlined immediate steps which must be taken by all state departments and commissions in order to facilitate the continuation of essential state services. In accordance with the governor's instructions, the Illinois Public Aid Commission has adopted measures to reduce expenditures which are to remain in effect until further notice. Among the steps that have been taken to curtail expenditures are an immediate freeze on the payroll status of all personnel and disapproval of new staff appointments and replacements.

At its meeting in January, 1961, the Committee discussed proposed legislation to implement the Kerr-Mills bill and establish a Medical Aid to the Aged program in Illinois. At the July meeting the committee reviewed the Rules and Regulations governing Assistance to the Medically Indigent Aged that had been adopted by the commission at its meeting of July 10, 1961, contingent upon the governor's approval of legislation establishing this new program. After discussion of the Rules and Regulations, the committee decided to appoint an emergency committee to analyze the proposed program which limited services to be included to hospital care and care by a physician for 30 days after the patient's release from the hospital. The committee agreed that a meeting of the House of Delegates should be called to discuss

the program since its success would depend on the cooperation of the medical profession. In accordance with a recommendation of the committee, a representative group of the state medical society met with the Illinois Public Aid Commission on August 30, 1961, to discuss implementation of the new program, to present the position of the medical society and make recommendations for changes before the program was put into operation. At its meeting of September 8, 1961, the commission reviewed the major objections of the state medical society to the limitations of the program and acted to expand the definition of essential medical care, for the purposes of the Aid to the Medically Indigent Aged program. The change in the definition provided for payment for physicians' services during hospitalization for persons eligible for the program.

The committee has been informed that it is the intent of the Aid to the Medically Indigent law that the Illinois Public Aid Commission stay within the \$20 million appropriation. It is understood that the Illinois Public Aid Commission plans to assess the new program every six months and add additional services if experience indicates that this can be done.

The number of active cases in the Assistance to the Medically Indigent Aged program totaled 638 at the end of December, or 282 more than the previous month. Both sections of the state increased - Cook County from 104 persons to 282 and downstate from 252 to 356. Since the inception of the program in August, a total of 1,775 applications have been received. Of this number 694 were accepted for assistance, 626 denied or otherwise disposed of, and 455 were still pending at the end of the year. Major reasons for denying cases during the past five months were: application was for services other than those provided, 20 per cent; applicant had sufficient income or assets, 16 per cent; and responsible relatives determined able to meet medical needs, 14 per cent. Since August, 56 cases were closed; 28 because of death and 21 transferred to Old Age Assistance.

Over-all caseloads in the public assistance programs in Illinois have increased by 48,139 persons, or 12 per cent during 1961 and currently comprise 4.4 per cent of the population. Over 12,000 persons were added during December, the third month of the current up-

trend in caseloads. In December, 1961, the number of persons receiving assistance was 445,935, an increase of 12.1 per cent from a year ago. Expenditures for all assistance programs in December, 1961, amounted to \$24,415,937, an increase of 23.4 per cent from a year ago. Also, \$462,442 were expended for AMIA.

Recent studies of expenditures for medical care in the federally-aided old age assistance, blind assistance, aid to dependent children and disability assistance programs for the period 1953-1960 show an increase in over-all costs from \$23,506,000 in 1953 to \$41,328,000 in 1960, and an increase in per capita costs from \$10.06 in 1953 to \$14.03 in 1960. Medical care expenditures, which constituted 21.6 per cent of total expenditures in 1953, had increased to 26.1 per cent by 1960. The proportion of total expenditures for public assistance now being spent for medical care is of increasing concern to the Illinois Public Aid Commission. For the last two years, figures on payments to individual physicians and pharmacies have been available, and reports on the practices of physicians where there appears to be a pattern of excessive services and an inappropriately expensive treatment pattern have been presented to the committee for review and advice. The committee has frequently made recommendations that a physician be dropped from participation in the medical care program for reasons deemed sufficient to justify such action, and the Illinois Public Aid Commission has generally acted in accordance.

The committee has recently been informed that the commission has adopted a policy in regard to reinstatement of vendors. This step was taken because of very serious difficulties experienced with some vendors, particularly pharmacies. The new policy provides that only in very unusual situations will business relationships be resumed with practitioners, vendors of medical services and supplies, or other vendors who have violated the commission's rules and regulations. When this policy was adopted the commission also recommended that all vendors with whom business relationships have been discontinued because of fraudulent violations of the rules and regulations are to be referred to the frauds section of the attorney general's office for appropriate action. While the commission found it necessary to have a policy in

relation to reinstatement of practitioners and other vendors of medical services and supplies who have been dropped, the committee has been assured that the commission will continue to refer all reports pertaining to irregularities by physicians to the committee for review and recommendations before acting to remove them from participation in the program.

The committee has continued its practice of inviting chairmen of county medical advisory committees to attend meetings and participate in the discussion. Problems referred by local committees for review and advice, and recommendations submitted by local committees are brought to the attention of the committee and receive careful consideration. During the past year, the Illinois Public Aid Commission changed its policy in regard to payment for anesthesia on the basis of recommendations made by the committee. The committee has advised the Illinois Public Aid Commission to change its policy of long standing with respect to payment to physicians for services rendered to public assistance recipients in hospitals in Cook County, and the committee has been advised that this recommendation is under consideration but has not been approved because of probable astronomical costs. Other recommendations submitted to the Illinois Public Aid Commission by the committee have been deferred because of increased costs.

A subcommittee on Physician's Fees was appointed in 1961 to study requests for increased fees for physicians in certain areas of practice and make recommendations. The committee as a whole accepted a recommendation of the special subcommittee that no action should be taken to recommend changes in fees for any one segment of physicians' services until the state medical society has developed and adopted a relative value schedule for all areas of physicians' services.

B. E. Montgomery, Chairman William H. Whiting, Vice-chairman Earle P. Semon R. C. Muehrcke Herbert V. Fine

Lee N. Hamm Harry G. McGavran John H. Steinkamp J. R. Schlereth Wm. H. Schowengerdt Fred A. Tworoger Elliott F. Parker Ex-Officio: Edwin S. Hamilton, President

George F. Lull, President Elect E. A. Piszczek, Chairman of the Council

COMMITTEE ON MEDICAL ECONOMICS

The 1961 House of Delegates and the chairman of the Council assigned three broad subjects and several additional items to the Medical Economics Committee for study and action. Committee meetings were held in July 1961 and in January 1962. Subcommittees were appointed to cover appropriate projects and these have been active and productive.

1. The Social Security Poll. This committee was assigned the task of polling the membership on social security coverage for physicians. This has been done and the physicians of Illinois have decided against being covered by social security.

The committee followed the dictates of the 1961 House of Delegates to give adequate publicity to the poll, to present the arguments both pro and con and to emphasize to all voting that coverage under social security is compulsory for all in the group. Question 3 was worded "Are you in favor of compulsory social security for all physicians?" Each county was given the opportunity to conduct its own poll and to report the results to the state society. Only five counties (Henry, Mason, Peoria, Pike, and Tazewell) did so. Ballots were tagged by county to obtain the county vote. The committee wished to know the various age groups of those voting and also to determine how many physicians are now covered (and want this coverage) by social security. This information was reported in detail in the December 1961 Journal. The accompanying table presents the final tabulations on the over-all vote.

Although an analysis of the poll already has appeared in the Journal, a further word is in order. Slightly over 60 per cent of our members voted. What happened to the other 40 per cent? Indeed, this is a challenge to each of us, to interest all our members in active participation in organized medicine.

The Cook County doctors voted in favor of social security while the downstate physicians were against coverage. Lake County and six other downstate counties here equally divided on this question. One is led to think that more discussions are necessary on medical economic and political problems at the county and branch society level.

The House should realize that the cost of conducting such a poll is high. In printing and mailing costs alone \$750 was spent. The manpower and time involved in tabulating over 6,000 ballots, plus the energy involved in the publicity work, meetings, and analysis is overwhelming. Consideration of these factors must be given before hastily suggesting "poll the membership."

However, the committee received great satisfaction from the Society's acceptance of the role in conducting the poll, plus the kind response of the membership to the fulfillment of this chore.

2. Formulation of a Retirement Program for the Members of the Illinois State Medical Society. The 1961 House of Delegates, by resolution, asked this committee to formulate a program in readiness for either the passage of the Keogh bill, which was then before Congress, or the professional associations bill then

RESULTS OF SOCIAL SECURITY POLL, STATE OF ILLINOIS BY AGE, FEBRUARY 20, 1962

	Question 1 Are you now covered by social security?		If you are r by social s	tion 2 now covered security, do o remain so?	Are you i	tion 3 n favor of ocial security all physicians?
Age	Yes	No	Yes	No	Yes	No
Under 35	134	324	79	48	103	359
35-44	411	1,287	310	84	723	1,041
45-54	407	1,383	345	40	886	921
55-64	262	895	211	28	644	519
65-74	139	455	117	11	307	284
75 and over	41	183	37	1	88	132
No age	29	88	20	4	61	71
Totals	1,423	4,615	1,119	216	2,812	3,327

before the state legislature. A subcommittee has been formed and retirement plans of various sorts are under consideration. The Keogh bill was passed by the House of Representatives in June. A modified version was favorably reported by the Senate Finance Committee in September. However, Congress recessed without action. The modified version remains in the Senate Finance Committee. The chances of favorable action in the current reconvened session are indefinite.

The Professional Associations bill (S.B. 804) was enacted in Illinois in June 1961. The committee suggests that individual members as well as those now in group practice or partnership practice proceed slowly under this procedure and only after competent legal and accounting advise. Although the state law allows the formation of such groups under state corporate structure so that tax deductible retirement funds may be established, the Internal Revenue Service takes a very dismal look at any procedure designed solely to evade the payment of tax. Should this law be upheld, appropriate suggestions will be forthcoming. To proceed now might involve serious financial repercussions for those involved, due to the time and energy expended in tax reviews plus the payment of high interest on money owed to the government as well as the possible necessity of paying large amounts during a financially embarrassing period. Since several groups of physicians now organized as clinics are studying the problem the committee suggests that our members await the results of these actions.

A plan for gaining retirement benefit by deferring income through Blue Shield, similar to that operated by the Montana Physicians' Service, is being studied. However, many obstacles would be encountered under such a plan in Illinois.

The committee does feel that a study should be made toward formulating a retirement program for our members — even without consideration of any tax deductible feature. A large group such as the Illinois State Medical Society possesses a quantity buying advantage in purchasing life insurance, disability insurance, and investments in stock and bonds. Many large counties, including Cook County, already have excellent insurance programs for

their members. The state society, acting as a unit, could be of special assistance to the physicians composing our smaller county societies and councilor districts.

The Council has approved such a study in principle and the committee is investigating this from many angles. We await the support of the House of Delegates as well as the interest of the membership.

3. Health Insurance Code. By resolution, the committee was asked to present a health insurance code to the 1962 House of Delegates. Such a code is designed to establish principles and ethics in health insurance. Adherence to such a code would be the rule of the Society when meeting with insurance companies, management, labor, and consumers. A subcommittee has been studying this. We debated the value and practicality of such a code. Yet our studies have convinced us that such a code will be of value. The code must be simple and to the point. It must be carefully worded. This requires time for proper preparation. When the finished product is ready, it will be reported to you.

4. Resolution #11, Special October House of Delegates Session. The resolved of the resolution reads as follows:

"Now therefore be it resolved that the president of the Illinois State Medical Society appoint an Ad Hoc committee to study the legal status of the Illinois State Medical Society and recommend the proper legal procedures to be undertaken so that the Illinois State Medical Society and its component county medical societies can legally 1) engage in collective bargaining for the terms and conditions of employment of its members, 2) engage in political activity and 3) elect its own members as it sees fit and without danger of court action as a monopoly, be removed from the danger of prosecution under the anti-trust laws."

With the approval of the sponsor, this resolution was withdrawn from the floor at the special House session and referred to this committee by the Council for study. This action was reported to the Council:

"This resolution would require the Society to adopt the legal status of a union in order to negotiate fees with the Government and other third parties. This involved an extremely basic decision of the membership. Your committee feels that the time for such a decision is not appropriate and that the resolution should remain under further study."

5. Other Activities. The committee has held informal meetings with representatives of commercial health insurance companies in an effort to solve communal problems. Progress of a sort has been made. Other discussions have been conducted concerning several medical economic problems.

Other committees have economic factors under consideration and there is some overlapping in this. In some ways, economic thought may be bypassed with the feeling that another group is working on a particular item. Each committee's activity should be spelled out through a meeting of all economically oriented committees at the beginning of the year.

The chairman is grateful to the members of the committee for their interest and devotion to work for the cause of medicine. As a group, we are thankful for the support of the Council and its chairman. The work of this committee was aided by the efficiency and the industry of the Society's economics staff, headed by Mr. Roger White. We are fortunate to have Mr. White and his associates serving us.

John R. Wolff, Chairman Norris L. Brookens Clifton L. Reeder Irving S. Schipper I. E. Bartlett Carl E. Neuhoff
J. A. Stocker
Laurence F. Rockey
Maurice M. Hoeltgen
Philip C. Lynch
Walter Stevenson

COMMITTEE ON RELATIVE VALUE

In June 1961 the Relative Value Committee embarked upon an arduous and exciting adventure in the intricate realm of business statistics.

After eight months of continuous effort, the essential data for a Preliminary Relative Value Index have been assembled.

The project was initiated by resolution at the 1961 annual meeting of the House of Delegates, delegated to this committee by the Council, financed by Society funds supplemented by financial assistance from the American Medical Association, and implemented by the committee, essential staff personnel, and employed professional statisticians.

The first item of business was the appointment of a staff executive, Walter Livingston, whose competence and dedication to service have been amply proven throughout the past eight months.

Competent, disinterested professional statisticians were sought and screened. Those ultimately employed were Frederick Ekeblad, Ph.D., chairman, department of business statistics, Northwestern University and Boris Parl, Ph.D., assistant professor of business statistics, Northwestern University. These were fortunate choices as subsequent events have demonstrated.

The Preliminary Relative Value Index has been brought to its current status by a succession of component projects: exhaustive research, assembling and precisely defining over 1,800 specific professional services and coding same, devising a survey, developing a questionnaire for surveying fees normally charged by Illinois physicians for a sample of 613 selected services, testing a prepaid mailing list for 13,000 physicians in Illinois by a preliminary first-class mailing, addressing and mailing questionnaires, editing 4,400 returned questionnaires, keypunching 195,000 separate IBM cards, programming the results, and delivering the mass of emerging statistics to the consulting statisticians for scientific analysis. For a detailed description of the statistical methods employed, consult the attached Statisticians' Report.

Unfortunately, even machine processing requires time, and processed data were delivered to the committee seven weeks past the target date posted in the original timetable. Three weeks of this deficit were made up by the statistitians who delivered their final report, subject to editing, on February 12. The committee was then confronted with the colossal task of expanding the index to include 1,800 items by interpolating approximately 1,200 additional relative values for services between the 613 "anchor" items obtained by survey.

To facilitate this task, six workshops were organized and conducted on February 17 under the leadership of a like number of temporary subcommittees chaired by regular members of the Relative Value Committee.

Sixty-six members of the Illinois State Medical Society participated in these workshops — a minority as members of the six subcommittees

and a majority as authorized representatives of the various specialty societies and the Illinois Academy of General Practice. These men toiled for long hectic hours — some until well after midnight.

The following day, February 18, the entire group met in joint session to hear and tentatively appraise the reports presented by each of the six workshops. All reports were unanimously approved on the basis just indicated. The Relative Value Committee is deeply grateful to these men for their valuable contributions to the committee's efforts, to Drs. Ekeblad and Parl, and to the staff assistants assigned to the workshop conference.

As of this date, interpolations, recommendations, and criticisms are being organized for formal study and evaluation by the Relative Value Committee, the consulting statisticians, and selected advisors from the specialty groups and the Illinois Academy of General Practice.

A supplementary report will be filed at a later date, together with the preliminary relative value index.

C. Elliott Bell,	Max Sadove
Chairman	Wilson R. Scott
Walter C. Bornemeier	John C. Smith
R. Gregory Green	Ex-officio:
Gershan K. Greening	Edwin S. Hamilton
Joseph G. Gustafson	E. A. Piszczek
Franklin J. Moore	Jacob E. Reisch

REPORT ON THE STATISTICAL FINDINGS OF THE RELATIVE VALUE STUDY

PURPOSE OF THE STUDY

The purpose of the study was to obtain factual data by the use of objective statistical methods on the fees charged by physicians in Illinois for 613 selected medical and surgical procedures. The resultant average dollar fees were then to be converted into Relative Value Indexes.

Source of Data

To obtain data on the fees charged, a questionnaire was designed which included 613 medical and surgical procedures. The nomenclature of the procedures, with few exceptions,

was based upon the definitions used in the suggested relative value questionnaire prepared by the American Medical Association and similar relative value studies by the state medical societies in California and Michigan. In addition to the information on fees charged for the procedures performed by a physician, he also was requested to provide information on the number of times the procedure was performed by him in the past 12 months.

Originally, the survey was designed as a stratified probability sample, divided into 33 subgroups by 3 geographic regions and 11 specialty groups. The three geographic regions were determined on the basis of the United States Census of Population of 1960. Table 1 shows the population and the number of physicians in each of the three geographic areas. (The list of the suburbs included in the Chicago area, with the corresponding 1960 population figures, is presented in Appendix I. The list of places with population over 25,000 outside Chicago and suburbs, is presented in Appendix II.)

TABLE 1

Region	Total Population	%	No. of Physicians	%
Region I:				
Chicago wi	th			
contiguous				
suburbs	4.3 mill.	42	7,859	60
Region II:				
Places with				
a population	n . 15:11	14	2,797	21
over 25,000	1.5 mill.	14	2,191	21
Region III: places with				
a population	n			
under 25,00		43	2,361	18
,				100*
TOTALS *Percentages do	10.1 mill.	100*	13,017	100
Tercentages do	not total 100	ude to four	iding.	

The 33 subgroups which were obtained by cross-classification of the geographic areas with 11 specialty groups are shown in Table 2. The number of physicians belonging to each of the subgroups according to the American Medical Association's list of physicians also is shown in Table 2.

By the use of random tables one-fourth of the physicians in each of the 33 subgroups was selected to be included in the sample, thus providing representation of all specialty groups in each of the three geographic areas. Three thousand, two hundred fifty-four physicians were thus included in the sample.

Table 2

	Number of Physicians By Subgroup Specialty and Place-Size Category										
	Group Specialty	Reg. #1	Reg. #2	Reg. #3	State Total		Group Specialty	Reg. #1	Reg. #2	Reg. #3	State Total
2.	General Practice Anesthesiology	2,559 151	613 70	1,603 44	4,775 265	9.	Ophthalmology Psychiatry Psychiatry,	426	168	105	699
3.	Internal Medicine Cardiovascular	1 120	207	20.4			Neurology Pediatrics Gastroenterology	518 374	110 137	89 77	717 588
4.	Disease Gynecology Obstetrics Obstetrics.	1,128	267	204	1,599	11.	Allergy Aviation Medicine Bacteriology				
5.	Gynecology Orthopedic Surgery Plastic Surgery	516	199	93	808		Dermatology Hospital Administration Industrial				
6.	Surgery Thoracic Surgery Radiology,	1,042	386	323	1,751		Medicine Neurology Neurological Surgery				
7.	Roentgenology Clinical Pathology Pathology Pathology, Pathologicanatomy, Clinical	252	98	68	418		Public Health Physical Medicine Proctology Pulmonary Disease Urology Medical				
8.	Pathology Otology, Laryngology, Rhinology Ophthalmology, Otology, Laryngology	189	67	43	299		Administration Occupational Medicine Legal Medicine Preventive Medicine	705	246	148	1,099

The questionnaire was mailed on September 1, 1961, to all physicians in Illinois. The questionaires to physicians in the sample were coded by their specialty group and the region. In order to maintain complete anonymity of the individual respondents, no further identification of questionnaires was made. Three follow-up letters were mailed to all physicians. The final deadline for including a returned questionnaire in the survey was October 10, 1961.

About 4,400 questionnaires were received. One-fourth of these were found to belong to the sample group. This sample response was considered too small for the desired representation in all groups concerned. However, because of the requirement to maintain complete anonymity, it was not possible to apply any individual follow-up procedures to the nonresponding physicians included in the sample

group. Therefore, it was decided to include all the responses in the final analysis of the data.

The returned questionnaires were edited for accuracy in following directions and for completeness of the required data. Questionnaires returned by physicians who did not report charges on a fee-for-service basis, such as interns residents, institutions and government employed physicians were excluded from the final summary. Three thousand, six hundred seventy-seven questionnaires were included in the final analysis. This represents 37 per cent of all physicians engaged in private practice in the state of Illinois.

The information on the questionnaires was then machine-processed. An IBM card was prepared for each physician for each procedure performed by him. Thus a total of 195,000 cards was obtained.

The percentage of physicians included in

the survey from each specialty and geographic group was then determined and used to arrive at proportional representation for each group in the study. The data from subgroups with less than the average (37%) response were weighted more heavily than the information obtained from groups with above average response. Thus, in the over-all summary the information obtained from each group carries the weight proportional to the number of physicians in that group. This procedure was used to eliminate the otherwise possible overrepresentation of responses from some of the listed specialty groups or geographic areas.

DATA REPORTED BY PHYSICIANS

The questionnaire requested information from each physician on:

- 1. His specialty group. Necessary for classification purposes and for weighting of the sample results.
- 2. His place size category as shown in Table 2, as region 1, 2, or 3.
- 3. His normal fee for any of 613 listed procedures that he customarily performed.
- 4. The number of times he performed each procedure during the last 12 months. This information on frequency of performance was necessary to give proper weight to those fees reported by physicians who performed the procedure quite often in contrast to the fees reported by physicians who rarely performed the procedure. For example, if physician A is a specialist in a procedure and performed it 150 times at a typical fee of \$100, and physician B performed the procedure only 2 times at a fee of \$50, it would not be appropriate to report an average fee for this procedure of \$75. A proper average would be quite close, if not equal to, \$100, the fee which actually predominates for this procedure.

Thus, the study emphasizes the typical fees charged by physicians who customarily performed the procedure.

ANALYSIS OF DATA

1. Forty-eight groups of physicians were analyzed separately. These groups were:
(a) All physicians in the state; (b) three

separate place-size groups; (c) 11 separate specialty groups; and (d) 33 separate specialty-within-place-size groups.

Separation into these groups made it possible to provide information on any difference which might exist between such groups and, equally important, to check whether it was necessary to use the specialty and place-size controls in order to validate the sample.

We note that significant differences exist among the control groups, and we recommend that similar controls be applied in any future study.

- 2. Three statistical measures summarizing the data were then calculated for each medical procedure in each of the 48 control groups. These measures were the *median* dollar fee for the procedure, the *first quartile* dollar fee, and the *third quartile* dollar fee. Interpretations of these measures are:
- a. Median dollar fee: This is the dollar fee such that half the fees charged were larger and half the fees were smaller. The median also has the important property of being the closest possible figure to all the individual fees. A simple example makes this properly clear. Suppose we have the following five dollar fees for a procedure: 50, 50, 75, 100, 150. The median of these is \$75. If we take the difference between this \$75 and each of the fees and then add these differences, we get a total of \$150 as shown below.

Dollar Fee median of \$75 50 25 50 25 75 0 100 25 150 75		
50 25 75 0 100 25 150 75	Dollar Fee	Difference from median of \$75
75 0 100 25 150 75	50	25
100 25 150 75	50	25
150 75	75	0
	100	25
150	150	75
		150

It is impossible to get as small a total sum of differences between these fees and some standard fee other than the \$75. For example, if we take the differences using the mean or the mode, two commonly recommended averages, we get total differences of \$160 and \$175 respectively (see next page).

Difference between	Difference between
Fee and Mean (\$85)	Fee and Mode (\$50)
35	0
35	0
10	25
15	50
65	100
160	175

- b. The *first quartile* is the median of the lower half of the data. It is thus a figure such that 75 per cent of the fees are larger than it and 25 per cent are smaller.
- c. The *third quartile* is the median of the upper half of the data. Twenty-five per cent of the fees are larger and 75 per cent smaller than the third quartile fee.

The values of the two quartiles give us information on the *uniformity* of fees. For example, if procedure A shows quartiles of \$68 and \$82, procedure A fees are more uniform than those of procedure B with quartiles of \$50 and \$100.

3. The medians and quartiles were then converted from dollars to ratios, thus resulting in the Relative Value Indexes (RVI). The fee for a routine office visit was used as a base. A simple example will illustrate the technique. (The data used in this example are fictitious.)

Procedure	First Quartile Q ₁	Median Md	Third Quartile Q ₃
Routine Office Visit Tonsillectomy RVI	$\frac{{}^{\$}_{50}}{{}^{50}_{50}} = 6.2$	$\frac{\begin{tabular}{c} $10 \\ 100 \\ \hline 100 \\ \hline \end{tabular}}{100} = 10.0$	$ \begin{array}{c} $

Thus three RVI's were computed for each procedure in each of the 48 groups. If all physicians adhered to some standard scale of relative fees, these three RVI's would be the same in a given group. For example, suppose a tonsillectomy was considered to be worth 10 routine office visits by all physicians. We then have medians and quartiles as follows:

Procedure	Q_1	Md	Q ₃
Routine			
Office Visit	\$ 8	\$ 10	\$ 12
Tonsillectomy	80	100	120
RVI	10.0	10.0	10.0

The differences in the three RVI's therefore reflect to some extent the degree to which physicians do not adhere to any general scale of relative fees either by choice or because they have no reliable information on which to base such a scale. We emphasize "to some extent" because it is possible for the RVI's to be all the same even if there are substantial departures from any scale of relative values. For example, if physicians who charge a below-average fee for a routine office visit were to charge an above-average fee for a tonsillectomy, and vice versa, the quartiles and medians would look just about the same as they would if the below-average office fee was paired with the below-average tonsillectomy fee.

Although such a reversal of fee positions from below-average to above-average is conceptually possible, it is not likely. Hence it is reasonable to assume that the differences in the RVI's reflect mostly the degree to which relative fee scales do not prevail.

- 4. Final Relative Value Indexes. The RVI based on the ratio of median fees was selected as the best single RVI for a procedure with a very few exceptions. The few exceptions resulted when gaps in the distribution of dollar fees in some of the less common procedures produced somewhat erratic medians and quartiles. The final RVI was then modified from a ratio of simple medians in order to better reflect the peculiarities of the particular distribution.
- 5. The Variability Factor (VF). Not all RVI's are equally reliable measures of relative fees. The evidence indicated that the fees for some procedures tended to be standard in dollar terms rather than in relative value terms. For example, almost every physician might charge close to \$100 for a given procedure regardless of his level of fees for other procedures. In such a case the RVI's based on medians would differ significantly from those based on quartiles.

Also, some procedures are quite variable by their very nature. Different physicians might charge apparently quite different fees for the same procedure when in fact they each handle only certain special types of cases within the general class. Such variability in the procedure itself would also result in different RVI's depending on whether medians or quartiles were

Hence, it is desirable to report some measures of the variability in the RVI for each procedure. Such a measure was calculated by taking half the difference between the RVI's based on the quartiles. For example, earlier we showed a case where the RVI was 6.2, 10.0, or 11.7 depending on whether first quartiles, medians, or third quartiles were used. The VF would be calculated as:

$$\frac{11.7 - 6.2}{2} = 2.8$$

The final report would show an RVI of 10.0 and a VF of 2.8 for this procedure. The interpretation of the 10.0 and the 2.8 is essentially as follows: roughly half the *relative* fees for that procedure fall between 7.2 and 12.8 times the fee for a routine office visit.

VALIDATION CHECKS

All of the final RVI's and VF's were examined for reasonableness. Consideration was also given to the number of physicians who reported on the procedure and on the number of times the procedure was performed. As a result, some of the RVI's and VF's were rejected as being based on insufficient and/or erratic data. An RVI value was not considered meaningful if the average, for example, was based on the reports of only two physicians who performed the procedure only six times.

Also, it is not appropriate to report the few cases in which there is evidence that substantial misunderstanding apparently existed on the nature of the procedure listed in the questionnaire. For example, a few cases turned up with fees for a procedure ranging from \$15 to \$400. Any average of such data would tend to be misleading. A few of the suspect situations were salvaged by backtracking through the basic data and discovering the apparent cause of the peculiar results. The preliminary RVI's and VF's were then adjusted for consistency.

Herewith we submit the statistical findings

of the Relative Value Study which are based entirely upon the factual information reported to the Relative Value Committee by the responding physicians. In the analysis and presentation of the results we have applied statistical procedures which we consider are most appropriate in summarizing the data in the form of Relative Value Indexes for the entire State of Illinois for all physicians of all specialty groups combined.

Frederick A. Ekeblad, Chairman Boris Parl

APPENDIX I

List of Suburbs Included in the Chicago Area and Their Population, 1960 Census

	City	Population
1.	Berwyn	54,224
2.	Blue Island	19,618
3.	Burnham	2,478
4.	Calumet City	25,500
5.	Calumet Park Village	8,448
6.	Chicago	3,550,404
7.	Cicero	69,130
8.	Dolton	18,746
9.	Elmwood Park	23,283
10.	Evanston	79,283
11.	Evergreen Park	24,178
12.	Forest Park	14,458
13.	Forest View	6,239
14.	Franklin Park	18,322
15.	Hometown	7,479
16.	Lincolnwood	11,744
17.	Marrionette Park	2,354
18.	Morton Grove	20,533
19.	Niles	20,393
20.	Norridge	14,087
21.	North Riverside	7,989
22.	Oak Lawn	27,471
23.	Oak Park	61,093
24.	Park Ridge	32,659
25.	Riverdale	12,008
26.	River Forest	12,695
27.	River Grove	8,464
28.	Riverside	9,750
29.	Schiller Park	5,687
30.	Skokie	59,364
31.	Stickney	6,239
32.	Summit	10,374
33.	Wilmette	28,268

APPENDIX II

List of Places with Population over 25,000 Outside Chicago and Suburbs, 1960 Census

10010	e omene and and a	~ . ,	10.	narvey	29,071
	City	Population	17.	Highland Park	25,532
	City	ropulation —	18.	Joliet	66,780
1.	Alton	43,047	19.	Kankakee	27,666
2.	Arlington Heights	27,878	20.	Maywood	27,330
3.	Aurora	63,715	21.	Moline	42,705
4.	Belleville	37,264	22.	Park Forest	29,993
5.	Bloomington	36,271	23.	Pekin	28,146
6.	Champaign	49,583	24.	Peoria	103,162
7.	Danville	41,856	25.	Quincy	43,793
8.	Decatur	78,004	26.	Rockford	126,706
9.	Des Plaines	34,886	27.	Rock Island	51,863
10.	East St. Louis	81,712	28.	Springfield	83,271
11.	Elgin	49,447	29.	Urbana	27,294
12.	Elmhurst	36,991	30.	Waukegan	55,719

13.

14.

15.

Freeport

Galesburg

Granite City

Committees Assigned to Director of Public Relations and Field Services

GRIEVANCE COMMITTEE
PUBLIC RELATIONS COMMITTEE
Reports not available at this time

COMMISSION ON DISASTER MEDICAL CARE

The Commission on Disaster Medical Care has met by telephone and at a special meeting held in Chicago during the AMA meeting on Disaster Medical Care. The following projects have been considered by the committee:

- 1. The establishment of a prototype manual for Disaster Medical Care in hospitals. This manual is presently being edited in the office of the Illinois State Medical Society and will be distributed in the near future to each county medical society in the state of Illinois, for redistribution to hospitals. While many hospitals already have disaster medical plans, there are those institutions which are still in the process of formulating such plans. The commission felt that an outline of such a plan would be useful to these hospitals.
- 2. It has been recommended that, for various reasons, physicians offer courses in disaster medical care for citizens of each community. It has become apparent that one of the best methods of doing this will be through our

cooperation in implementing the Medical Self Help Program. In the state of Illinois, the Civil Defense Agency has delegated responsibility for this program to the State Department of Public Health. It is particularly fortunate that the director of public health for the State of Illinois is a member of this commission. The commission felt that all physicians should be acquainted with the Civil Defense Emergency Hospital. The USPHS is presently compiling a manual on the CDEH, and it is possible that portions of this manual may become available for reprints in the medical journals. If so, this might be excellent material for publication in the Illinois Medical Journal.

26,628

37,243

40,073

20.071

3. It is recommended that the medical society urge greater participation of hospital staffs in training programs for disaster medical care. This would include utilization of the talents of those physicians who have had such experience, and also the talents of our radiologists who can contribute much in training programs for radiation hazards, radiation detection, and radiation decontamination. If this program is implemented we should also participate in the training of allied medical personnel. Such training should include not only emergency medical and surgical care, but also the

problems of environmental health.

- 4. The commission hopes to have the cooperation of other medical groups in this field, such as the Illinois Hospital Association. The problems of disaster medical care must be of concern to the medical profession, all allied professions, and the Hospital Association.
- 5. In all phases of disaster medical training and preparedness, we must bring out the fact that such endeavors are a community problem. The Medical Self Help Program particularly should enable us to establish closer rapport between our profession and various labormanagement groups.

The subject matter under consideration by this commission has been presented at various places throughout the United States during the past several months. Among these were:

- 1. A broadcast on FM station WELF.
- 2. Health Services Mobilization Course Sun Valley, Ida.
- 3. Health Services Mobilization Course Wilmington, Del.
- 4. Health Services Mobilization Course Alameda, Cal.
- 5. AMA Disaster Medical Meeting.
- 6. Regional Meeting of X-ray Technicians.
- 7. Reserve Officers' Club at O'Hare Field.
- 8. Junior High School Principals of DuPage County.
- 9. Jackson County Medical Society.
- 10. Georgetown University Medical School Mend Program.
- 11. DePaul University School of Nursing.

Max Klinghoffer, Each Chairman LeRoy Fatherree J. Charles W. Young Fay S. Comer Ha

Earl H. Blair
Leonard F. Roblee
J. F. McCahan
Ex-officio:
Harold C. Lueth

ETHICAL RELATIONS COMMITTEE
FIFTY YEAR CLUB
PUBLIC SAFETY COMMITTEE
Reports not available at this time

COMMITTEE ON RURAL HEALTH AND STUDENT LOAN FUND

With the movement of the Illinois Agricultural Association home office to Bloomington, a few changes were made in the administration

of the loan fund. The state medical society's Chicago office is maintaining the month-to-month contact with the loanees as their problems arise. Virtually all the administrative work is being done by Mr. Roy Will, in the IAA Building in Bloomington. The First National Bank in Chicago continues to operate as trustee of the funds.

In the fall of 1961 the loanees and participants in the Farmer-Doctor Loan Fund program were entertained at dinner at the Student Union in Chicago. A very free discussion was held at this time, and the participants appeared to enjoy it. They heard firsthand from one of their recent graduates the story of his first year in practice. It is planned that along in May of '62 another meeting will be held with the senior group of participants. One of the problems is to keep track of where these young men go and to furnish them with up-to-date advice.

At the February 1 meeting of the board six young men were recommended for admission to medical school. Four young men were considered to be good risks for loans. It is apparent that the amount of money in the loan fund will start revolving in 1963 in a satisfactory manner. Some years we will be able to make a few more loans, and other years a few less, but the program is now revolving.

The most serious problem is to keep the participants apprised of their responsibility in connection with this program. A variety of techniques have been used to do this. The basic one still remains the character of the participant. The president of the county medical society is asked to sign an application for the participant, and when doing so, please make a conscientious effort to find out from all sources as to whether or not this boy is of good moral character and a man of his word.

Dr. Jack Gibbs, a member of the loan fund board is participating in the Rural Conference in Des Moines in May. His service in orienting the thinking of many people interested in the rural health problem has been wonderful. The entire Loan Fund board is grateful for his efforts.

There were a few more applicants for entrance to the state medical school from outside Cook County this year. Number and quality still leaves much to be desired. It seems to many of us that all men in practice must make

an effort to interest bright young men in their communities to take up medicine. Otherwise, maintenance of quality care of our people is going to be next to impossible.

Harlan English, Chairman E. S. Hamilton Jack Gibbs

STUDENT AMERICAN MEDICAL ASSOCIATION
Report not available at this time

ADVISORY COMMITTEE TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Every medical society should encourage the Illinois Medical Assistants. In those counties where they are chartered, they should be more actively sponsored. Where there are none, the societies should take the lead in developing chapters. Their program of self-improvement, recruitment, and their aid in public relations and legislation can be of inestimable help to the doctor and our profession.

The members of this committee have served the local chapters well in many ways as councilors.

This growing organization, now chartered in an increasing number of counties, is growing in membership and acceptance by the local county medical societies.

Two round tables have been held on a statewide basis, one in Bloomington, and another in Chicago for education. Adult education courses for medical assistants have been promoted in many counties.

Crane Jr. College has created, under the direction of the medical assistants and the advisors, several credit courses available for the Chicago area girls.

The chairman of this committee attended the national meeting this year. The serious intent of these people must be complimented. It will surely reflect on the physicians in better patient and office relations. Nationally, a program of education is being formulated, to lead to certification of the medical assistant.

The value of this organization to a local medical society is second only to the Woman's Auxiliary and more counties should sponsor and encourage the foundation of a society of medical assistants within their geographic area and encourage their girls to become members.

Carl E. Clark,

Chairman

Arkell M. Vaughn

Walter D. Stevenson Caesar Portes Fred L. Stuttle

Committees Assigned to Director of Publications and Scientific Activities

EDITOR, ILLINOIS MEDICAL JOURNAL

During the past year, the editorial department of the Illinois Medical Journal has carried on despite changes in printers, make-up, and reduced revenue from advertising. The latter has necessitated a 26 per cent reduction in the number of pages devoted to scientific material.

The function of the state medical journals has changed during the past decade, and our Journal is no exception. The socioeconomic problems of the profession are growing with such rapidity that more and more space must be devoted to medical organization, public relations, methods of influencing public opinion, fees, cost of hospital care, legislation affecting the medical profession, public health, medical

education, social security, relative value, and third parties. This does not mean that the clinical aspects of medicine are being de-emphasized; it means that we are devoting less space to these subjects. This realistic approach has merit because other journals are doing a good job of disseminating medical information, and duplication is a waste of time, money, and effort.

During 1961, 335 pages were devoted to clinical articles. There were 46 pages of editorials, 27 pages of book reviews, and 37 pages of odds and ends from the editor's desk. One feature has been added: The Anesthesia Conference, by Dr. Vincent J. Collins, head of the department of anesthesiology at Cook County Hospital.

During the past year, 126 pages were devoted

to official medical society business, including an interesting commentary by our executive administrator, Mr. Robert L. Richards. It is entitled "As I See It." There were 23 pages on medical economics, 14 on medicolegal topics, 50 on announcements, and 75 on news of the state.

Over 150 manuscripts were submitted during 1961; 32 were considered not suitable for publication. On February 1, 28 papers were still unpublished. Thirteen more were submitted during January. Three of them were regular features.

T. R. Van Dellen

EDITORIAL BOARD
Report not available at this time

JOURNAL COMMITTEE

During the past year the Journal Committee has worked industriously and harmoniously with the Director of Publications, Mr. Al Boeck, and the Editor, Dr. T. R. Van Dellen, in the production of the Illinois Medical Journal and the effecting of three major changes:

- 1. Selection of the Neely Printing Company of Chicago as printer of the Illinois Medical Journal. After a one-year study of the special needs of the IMJ, and solicitation of bids from several printers, including our former printer, a decision was made to change to the Neely Company. Thus far we have been more than satisfied with the quality of printing done by Neely, the cooperation of this company and the cost of the Journals published there.
- 2. Establishment of the position of Advertising Manager on a full-time basis. As a means of coping with the severe loss of advertising revenue and to provide production skills lacking on the Journal staff, the position of Advertising Manager was made full-time and broadened to cover all production matters. Mr. John Kinney was hired to fill the position and is performing his duties in good fashion. This change was accomplished without additional expense to the Journal budget.
- 3. Introduction of a new format. The long-promised redesign of the Journal was presented with the October, 1961, issue. Complete with new cover, the Journal appeared with all new

body type, new headline schedule, and several other innovations designed to make the Journal easier to read and more attractive to both reader and advertiser. Several policy changes were made during the year, all after adequate and substantial investigation. These conform to the policies followed by other large state and regional medical journals and have been approved by the Council:

- 1. Acceptance of tobacco advertisements. This decision was made after it was ascertained that 22 state medical journals are currently accepting cigarette advertising. Editorial review of such advertising is, of course, maintained.
- 2. Acceptance of institutional alcohol beverage advertisements. Again, this was approved after a survey showed 18 other journals carrying such advertisements, many with no restrictions. The Illinois Medical Journal policy was defined as "institutional copy only" meaning that specific brand names not be permitted.
- 3. Subscription rates increased. These were defined as: single copies 60; by mail 75; \$5.00 per year domestic; \$5.50 per year Canadian; \$7.00 per year foreign. A special rate of \$2.00 per year was authorized for members of the Student American Medical Association, interns and residents.
- 4. A no-limit policy on number of reprints of articles appearing in the Journal. All reprints are subject to approval of the author. This again follows the policy of most other medical journals.
- 5. Development of a policy governing inclusion of prices in advertisements. This, in general, provides that prices may be listed for items not directly used in the care of patients.

FINANCIAL REPORT

The original advertising income estimate for 1961 was \$140,000 and the estimated production budget was \$135,000. The full effects of the advertising "depression" resulted in a decline to \$91,000 in advertising revenue. We were able to reduce production costs to \$102,800, thus limiting the deficit to about \$12,000 despite a loss of almost \$50,000 in advertising.

The Illinois Medical Journal is currently on a monthly pay-as-you-go basis designed to avoid any deficit in 1962. The advertising

picture has improved and a sales promotion campaign has already borne some fruit. It is our hope that revenue will increase sufficiently to permit further development of the Journal. Jacob E. Reisch, W. H. Palmer

Chairman
H. Close Hesseltine

Albert VanderKloot
Paul P. Youngberg

ANNUAL MEETING COMMITTEE Report not available at this time

COMMITTEE ON ARCHIVES

Your committee recommends that:

1. Physicians become more interested in medical history in both its scientific and legislative aspects. No normal individual cares to live entirely in the past, but none of us is so wise that he can afford to ignore the lessons which the past has for each of us. Someone has said that those who live contentedly (or otherwise) in the present, having little or no regard for what has gone before, usually care very little about what is going to happen in the future. Do too many of our physicians belong to the latter group? Or are we defeatists? Present dilatory tactics in our battle against socialized medicine would lead to one of these two conclusions.

Many doctors seem so well satisfied with what is occurring at present that they neglect medical history. We read little about the problems of our predecessors whose observations, investigations and discoveries have made our present medical progress possible. We also disregard the history of legislative activities in foreign lands which led to socialized medicine with its inevitable bad effects on medical care and progress. Present legislative proposals in our own country, if not prevented, can damage or nullify our own medical miracles and interfere with future medical progress. After looking at the present colossal problems in agriculture under federal and political mismanagement, can anyone imagine what will happen to medicine when our politicians take over?

2. The secretary of each component society report current items of historical or political interest to the "News of the State" section of the Illinois Medical Journal. This will place such historical material on file in our permanent records where it will always be accessible.

3. Historical material such as old records, old licenses to practice medicine, old fee bills, records of early medical societies or of activities of pioneer physicians be sent to the chairman of the Committee on Archives. Dr. Youngberg suggested two years ago that our hospital staffs collect items mentioned above and also medical books and surgical instruments. These can be put on display in our hospital libraries. We hope this suggestion will produce results.

Your committee has prepared a request which will be sent to the secretaries of each component Society requesting their cooperation in carrying out these recommendations. It also has suggested increased interest by our physicians in medical history, has solicited the cooperation of each county society in collecting and preserving material of historical interest and repeated Dr. Youngberg's suggestion about historical displays in our hospital libraries.

Tom Kirkwood, *Chairman*J. J. Moore, *Secretary*Paul P. Youngberg

MEDICAL EDUCATION AND HOSPITALS
Report not available at this time

CANCER COMMITTEE

The Cancer Committee met on October 25, 1961, to evaluate its past performance and outline further activities. Pressing answers of the committee should be to:

- 1. Bring the Medical Society information on cancer and to interpret the information to practicing physicians in Illinois.
- 2. Promote a lay program in cancer; to correct misinformation and misinterpretation to the public; promote sound and correct information on cancer; promote accurate information to the public whenever feasible; and to combat quackery.
- 3. The committee should be advising governmental lay agencies on the dividing of funds allotted to the various cancer programs.

The American Cancer Society has as usual carried on its good work in cancer education.

The American Cancer Society has recently produced a new Film — "The Life Story" — which is being released to lay group societies.

Caesar Portes,
Chairman
Augusta Webster,
Vice-Chairman
Warren H. Cole
Roger F. Sondag

Russell M. Jensen Franklin J. Moore Ernest D. Nora Thomas Sellett Wilson R. Scott

COMMITTEE ON CARDIOVASCULAR DISEASE

The Cardiovascular Section of the Illinois State Medical Society was represented in Chicago on September 17, 1961, by Doctor Richard E. Dukes of Urbana. He reported on the progress in the cardiovascular field in Illinois. It is the feeling of the committee that some additional facts should be presented as part of this report. It should be pointed out that a great deal of important work is being done in Illinois in physician education in the cardiovascular field. Recent developments are published in Newer Concepts, which is mailed to all physicians in the state. Every year we benefit through research that is carried on by the American Heart Association. In addition, we are fortunate in Illinois in having a research program that is conducted under the sponsorship of the Chicago and Illinois Heart Associations. Also, each of these associations has committees which meet regularly, whose work is devoted to rheumatic fever, physician education, and lay education. There are a number of heart units in the state that sponsor cardiac clinics. These clinics accept indigent school age children referred by physicians for diagnosis of cardiac lesions. Reports are returned to the physician with suggestions for further treatment and to the school that the child attends with recommendations concerning the degree of activity allowable for such a patient.

It is the writer's opinion that it is all the more laudable that all of the above projects are the result of voluntary contributions of time and money by physicians and laymen alike.

Arnold S. Moe, Chairman

COMMITTEE ON CHILD HEALTH

In the fall of 1961, the Council approved the consolidation of all committees concerned with child health into the Child Health Committee. This committee now includes what formerly were the Committees on Polio Control, on Infectious Diseases, on School Health, and on Handicapped Children.

The Child Health Committee has been impressed with three circumstances in the present status of health committees in Illinois:

- 1. There are many agencies throughout the state interested in various phases of child health, agencies which are working independently of each other. The result has been a duplication of effort, and often a neutralization of results because of the fact that groups are working without knowledge of each other's efforts, which are often at cross purposes.
- 2. An inordinate amount of time is required of committee members if they are to give effective service.
- 3. Most committees do not have statewide coverage, nor do they have access to adequate mechanical and financial facilities for attacking their problems on a broad and deep basis. The outstanding, although not the only exception to this is the ISMS with its well organized central office, its adequate budget, its complete state coverage thru its councilors, committees and officers and its effective relations with the state government.

With these three thoughts in mind, your committee has adopted on an experimental basis the concept of developing collaborated action between your committee and all other reputable groups in the state interested in the problems of child health. Each particular problem is to be the responsibility of an assigned member of your committee, who will work with the other interested agencies. The committee as a whole will enter the picture only after the subgroups have made their report. The committee will consider the report and take final action for presentation to the Council. In this way each committee member will limit his activity to the area of his special interest. After receiving a report of a subgroup, the committee may consider the report at a meeting, or more often, through a telephone hookup of the members.

This concept is being carried out in a number of ways:

- 1. The Appointment of Subcommittees, made up of members of your committee and members of other interested groups. These are subcommittees of the Child Health Committee of ISMS and are under its direction. Several such subcommittees are already active:
- a. The subcommittee on Fetal Mortality. The committee on Fetus and Newborn of the Illinois Chapter of the American Academy of Pediatrics has collected data which indicates that while the overall death rate in the newborn in Illinois is 16.7 per thousand live births, there are areas in which the death rate is as high as 50 deaths per one thousand live births. One, but not the only factor is inadequate medical services in these areas. Much needs to be done to determine all of the factors involved, and to develop methods of reducing the mortality rate. The Illinois Chapter of the AAP does not have the facilities for making such a study. To bring all available forces to bear on this problem, your chairman has appointed a subcommittee on fetal mortality. The chairman of this subcommittee is Dr. Herbert F. Philipsborn, Jr., who besides being a member of your committee, is chairman of the Committee on Fetus and Newborn of the Illinois Chapter of the AAP. Members include two members of your committee and two members of the AAP Commit-
- b. The subcommittee on School Health Councils and School Health Programs is chaired by Dr. R. E. Dukes and includes a member of your committee and a downstate physician interested in this problem. The subcommittee is working with the Department of Public Instruction and of Public Health and with the Governor's Commission to determine the extent to which these facilities are being utilized throughout the state. Your committee will consider steps to be taken when the subcommittee has made its report.
- c. The subcommittee on School Health Records. The Illinois Academy of General Practice has been interested in this problem and has made a number of recommendations through its Committee on School Health Examinations and Welfare, of which Dr. Howard R. Hone is chairman. Doctor Hone has been made a mem-

ber of your committee, and chairman of the subcommittee on School Health Records, which after further study will submit recommendations to your committee.

- 2. Sponsoring and/or Supporting the Ac-TIONS OF A HEALTH AGENCY INVOLVING A PROBLEM IN CHILD HEALTH. Dr. Edward F. Lis, who is a member of your committee and also the director of the Division of Services for Crippled Children of the University of Illinois, has brought to the attention of your committee proposed changes in the organization of state-supported children services. These proposed changes have been studied in cooperation with the Illinois Chapter of the AAP and the Chicago Pediatric Society. Your committee, at its meeting on November 19, 1961, recommended that the ISMS go on record as opposing the inclusion of the Division for Services for Crippled Children into a new department to contain most or all children services. Your committee has recommended:
- a. That it retain its present base in the University of Illinois,
- b. That a physician continue at the head of the division,
- c. That there be no segregated Division of Child Services created, but that the existing diversification of services be continued.

The Illinois Chapter of the AAP and the Chicago Pediatric Society concurred in these recommendations. These organizations together with the Council of the ISMS all have taken official action, and have advised Governor Kerner of this action.

- 3. The Appointment of a Liaison Representative to Another Agency. Your committee is working with the Joint Committee on School Health of Illinois. Among our points of common interest are competitive athletics in schools, health education for teachers, and a state level conference on physicians in schools. Dr. W. W. Fullerton, co-chairman of your committee and vice-president of the Joint Committee, is our representative and is coordinating the activities of the two groups.
- 4. ACTION OF THE COMMITTEE AS A WHOLE. Your committee feels that the current

problems of poliomyelitis control are of such importance that all of its members should take an active part. The Technical Advisory Committee in Polio Control to the director of Public Health of Illinois frequently asks for an official opinion from the ISMS on developments in this area. The chairman of your committee represents the ISMS on this advisory committee and keeps the Advisory Committee informed of the sentiment of the physicians of Illinois as interpreted by your committee and as approved by the Council. Much of this organizational plan of your committee is experimental. It is aimed at maximum utilization of the special talents of its members with a minimal expenditure of their time, and the broadest possible coordination of all activities in child health in Illinois. Next year's report should indicate the degree of effectiveness of this experiment in committee structure and activity.

John L. Reichert,
Chairman
W. W. Fullerton,
Co-chairman
Richard E. Dukes
Howard R. Hone
Ralph Kunstadter

William D. Larson
Edward F. Lis
Fred P. Long
Frank G. Murphy
Kenneth S. Nolan
Herbert F. Philipsborn
Arthur L. Shafton

COMMITTEE ON EYE HEALTH Report not available at this time

MATERNAL WELFARE COMMITTEE

With the elevation of Dr. Frederick H. Falls to the position of chairman emeritus, the Maternal Welfare Committee personnel composed of newly appointed and remaining members began their official year following the Society's Annual Meeting of 1961.

Our activities have included a review study of maternal deaths of downstate and Cook County Hospital with two regular meetings held on September 10th and November 26th in Chicago, with the conclusion of the 1961 cases at a third meeting to be held in late February, subsequent to submission of this report. Protocols of cases reviewed are developed and furnished by Dr. John Rendok, Obstetrical Consultant, Department of Health, State of Illinois.

As of this writing, excess blood loss from various causes is the largest single contributor to the extent of 26.9% of our maternal deaths. The educational atmosphere of our transactions are enriched by the academic pathological studies furnished by Dr. Santos and members of his department from Cook County Hospital. The committee feels that Dr. Augusta Webster, by having her resident staff present for their particular cases, identifies the committee in the minds of these young physicians as a post-graduate activity of the Illinois State Medical Society, and perhaps may be instrumental in their practice of desirable obstetrics.

The committee is gratified by the number of our colleagues requesting our impartial opinion on cases in which they have an interest, and a few have accepted invitations to attend and observe the complexity of problems confronting us in the discharge of our obligations to all parties concerned. Through such communication, we feel that the purposes of the committee's work have become better understood by the profession at large.

We have inaugurated the keeping of formal, desirable minutes of our meetings, with copies sent to all members. With the passage of Senate Bill 320, enabling more freedom of communication, we have accelerated our pace of sharing helpful information among the membership of the Society.

The first formal contribution on the subject of Afibrinogenemia has just been presented to the editor of the Journal for publication. The thoughts expressed in this article are a distillate of constructive prudent analysis of facts available for committee study. A subcommittee under Dr. Frederick Falls is in the preliminary stage of developing a registry for cases of hydatid mole and choriocarcinoma, in cooperation with the Department of Health of Illinois. When plans are ready for implementation, the profession will be invited and encouraged to participate in the study. The committee has been impressed with a resumé on perinatal studies presented by a guest appearance of Dr. Bulfin of the Little Company of Mary Hospital at our last meeting. We have expressed our interest in the problem through administrative channels, and shall await any assignment in

this field in accordance with policy of proper intercommittee relationship and function. As a beginning step, reciprocal liaison members are being appointed between our committee and the Committee on Child Health.

The program and panel of the Sixth Annual Congress of the Illinois Association of Maternal and Infant Health held February 7-9 in Springfield included participating members of our committee and the long-standing sustaining support and influence of the committee as a whole. We welcome constructive suggestion from the officers, Council members and fellow physicians on any occasion in order that we may constantly achieve what is best in the care of mothers and the newborn in the State of Illinois.

Members Present September 10, 1961

Dr Farley (Alt.)	C.D. #2
Dr. Rezek	C.D. #3
Dr. Young	C.D. #4
Dr. Loar	C.D. #5
Dr. Hartman	C.D. #6
Dr. Scrivner-Chmn.	C.D. #10
Dr. O'Donnell	C.D. #11
TO TO 1.	

Dr. Rawlings Dr. Hanrahan Dr. Rendok

Guests Present

Dr. Augusta Webster

Dr. Donovan

Dr. Cosandine

Dr. Hussey

Members Present November 26, 1961

Dr.	Owens	C.D. #1	
Dr.	Young	C.D. #4	
Dr.	Loar	C.D. #5	
Dr.	Hartman	C.D. #6	
Dr.	Scrivner-Chmn.	C.D. #10)

Dr. Hanrahan Dr. Rendok

Guests Present

Dr. Augusta Webster and Staff:

Dr. Bloodgood

Dr. Tadski

Dr. Kodonaja

Dr. Doolin

Dr. Leon - Illinois physician

Dr. Matthew Bulfin

The committee gratefully acknowledges the efficient cooperation afforded by the administrative staff through the representative of Mr. Al Boeck in facilitating our work.

W. C. Scrivner, R. R. Hartman Chairman I. B. Waller Frederick H. Falls. Carl Greenstein Chairman Emeritus C. K. Wells A. B. Owen J. R. O'Donnell W. J. Farley Augusta Webster G. Rezek John Rendok W. R. Young W. M. Hanrahan R. R. Loar D. Rawlings

COMMITTEE ON MENTAL HEALTH

With the preliminary deadline of February 1, 1962, no stated meeting of our committee has been held thus far. However, one was scheduled for February 2 and 3, 1962, at the time of the meeting of mental health representatives of state medical societies. The Council has generously had the committee in for these meet-

Activities of the committee thus far have been mostly those of contacts with various organizations. Some members of the committee attended the annual meeting of the Association of Mental Health; others have attended other meetings of similar nature. The committee has endeavored to follow through on activities of the new State Department of Mental Health and to cooperate with Dr. Gerty in this respect.

F. Garm Norbury,	Richard Graff
Chairman	Harry Nesmith
Francis J. Gerty	John J. Madden
Louis D. Boshes	Harold Visotsky
John Lester Reichert	Bernard Klein
Harry Phillips	Walter H. Baer
David M. Jordan	

COMMITTEE ON NURSING

The Nursing Committee of the ISMS wishes to report that its activities in the nursing field for this past year have been mainly in three areas: (1) study and evaluation of the Associate Degree Program; (2) survey of nursing needs and resources of the State of Illinois; (3) attendance at the biennial convention of the

Illinois League for Nursing.

The committee proposed and carried out a deployment of its members so they could attend meetings of various nursing organizations, practical nurses meetings and nursing home association meetings. As the members attended, they furnished for the committee files, a report of the proceedings and their impressions. While it was not possible for all the committee members to participate, a substantial amount of familiarization with the problems confronting the nursing profession was achieved.

At a meeting in Chicago the committee met and reviewed the file. The committee made a recommendation for the House of Delegates which appears later in this report.

The Nursing Committee wishes to report that the Associate Degree program is still very much in the forefront in the endeavors of both the Illinois League for Nursing and the Illinois Nurses' Association. A helping hand from the Illinois Hospital Association and the junior college deans gives the push for this program a strong front for action in 1963. ISMS was absent from this group because after considered judgment of the nursing committee which reported in May 1961, it did not recommend its outright approval. The required change in the nursing act was not requested in the closing days of the Illinois legislative assembly, because of the lack of ISMS approval. It was also postulated that an opinion of the attorney general on the interpretation of the nursing act would, if favorable, not be as satisfactory as opening the act and revising it in 1963. (Subsequently, the attorney general did not render a favorable opinion as to permitting Associate Degree programs within the present act.)

The Illinois League for Nursing, at its biennial convention, stressed above all other matters, the need and place of the Associate Degree program in nursing. The speakers felt the problems of training more nurses would be well favored by such a program. It was emphasized that the outlook for the diploma schools is not bright, and though several decades would probably pass before the Associate Degree program would supplant this form of nurses' training, the trend is quite positive. It was brought out that no new three year diploma schools have been opened in Illinois in the past several years, nor are any planned. The actual figures show

that between 1935 and 1957, there has been a drop from 123 nursing schools to 72, and of these 72, six are collegiate schools. Therefore, this indicates that the diploma schools have decreased by almost 50 per cent since 1935.

Briefly, the Associate Degree program consists of a two year course in nursing leading to an associate degree as an integral part of a community or junior college. It provides a means of correlating the philosophy and standards of nursing education with those of general education. The overall standards and policies of college curriculum are applied to the nursing program, and this program offers the nursing student the collegiate atmosphere, and collegiate life. The program is designed to meet the educational needs of qualified high school graduates. Two years of study in their own community enables the aspirant nurses to meet the requirements of the Board of Registration and Education in many states.

Instruction in all areas including the arts and sciences and nursing is provided by qualified college faculty members. The ratio of general education and nursing education courses has been developed in accordance with college policy and the regulations of the state licensing authority. Graduates of this program are prepared to give patient-centered care in the beginning general duty nurse positions. They are prepared to relate well with people and to cooperate and share responsibility for the patient's welfare with other members of the nursing and health staff. The Associate Degree graduate is prepared to be self-directed in learning from experience as a practicing nurse. Eligibility for licensure as registered nurses does not apply to all states in the United States at the present time. It appears that there may be as many as 60 per cent of the states which have provisions for such a program. As yet the State of Illinois does not permit the licensing of a nurse whose training has been less than three calendar years.

The committee feels that the program has merit and the nurses' organizations which are so zealously guarding the quality of nurses' training are for this program. The medical profession which should take the lead in overseeing the procurement of well-trained nurses must take a positive and affirmative stand on the Associate Degree program. At its January

21st, 1962 meeting the Nursing Committee developed this statement for presentation to the House of Delegates:

"The Nursing Committee of the ISMS asks the House of Delegates of the ISMS to endorse in principle nursing education in the junior colleges, this to be undertaken whenever and wherever practical as an added facility for nursing education and to assist in the cultural and professional training of nurses.

"Should there be any modification such as contracture of the present curriculum by law, the medical society then deems it prudent to request a guiding voice in any such changes and to thereby insure the best standard of nursing care possible for the patient's service and the completeness of the individual nurse's education."

In addition to the above position desired of the medical society to facilitate the training of increased numbers of nurses, shortening of the three-year diploma school curriculum was felt a desirable procedure to be explored so that full utilization of the established schools of nursing will be continued. On the survey of nursing needs and resources in Illinois, the chairman of the committee met with the representatives of organizations in nursing and allied fields. The purpose of conducting such a study has as its aim the assessment of the nursing force in the State, and evaluation of the training facilities, the evaluation of the inactive nurse population, and of great importance, the areas in which recruitment of nursing candidates might be profitable. No such study has taken place in this state since 1950. The goals of such a study are to offer those interested in nursing a blueprint of procedures and direction for all parts of the state in order to fill vacancies in the present nursing schools.

The difficulties encountered in such a study are many. All committee members have been actively engaged in attempting to secure aid from organizations involved in the care of the sick. The Illinois State Medical Society and the AMA will be asked to participate in this effort.

The Nursing Committee also had representatives at the meeting of the Practical Nurses' Associations meeting, as well as a meeting of the Nursing Home Association.

While it is impossible to cover all of the meetings, the committee has established good

rapport with the nurses' organizations and has obtained insight into the workings of these associations. The file compiled in this manner is a valuable record for future work of the Nursing Committee and the members of the ISMS.

Ted LeBoy, Maurice M. Hoeltgen
Chairman Anna A. Marcus
Angelo Creticos Mary Louise Newman
J. O. Firth Willard C. Scrivner
William K. Ford Lorin D. Whittaker
Leonard D. Grayson Paul P. Youngberg
Henrietta Herbolsheimer

COMMITTEE ON NUTRITION

The Committee on Nutrition has engaged in numerous activities during the past year. Our jointly-sponsored meeting with the Illinois Nutrition Committee was held at Northern Illinois University, DeKalb, October 7, 1961. The subject of the program was the School Lunch Program. The speakers included nutritionists, physicians, school personnel, the PTA, and a high school senior. The audience of several hundred was made up of home economists, nutritionists, dietitians, physicians, and school officials. What was said and done at that meeting received national publicity, not only in newspapers but several other news media.

Further activities will include a joint meeting with the Institute of Food Technologists and the Chicago Nutrition Association, September 26, 1962, in Chicago. The title of the meeting is "Symposium on Nutrition and Food Technology." This meeting will be of national and international importance.

We are again looking forward to a jointly sponsored meeting with the Illinois Nutrition Committee on October 6, 1962.

We are attempting to formulate a diet program for individuals and small groups in the event of protracted confinement from one cause or another. Valuable help has been received from Dr. William Bradley of the Milling Institute, Dr. Herman Meyer, a member of our Society, and Dr. Franklin D. Yoder and his staff.

Dr. Yoder recently was appointed head of the Illinois State Department of Public Health and is most interested in our continuing efforts in nutritional education. Individual activities of the committee members included a talk by Dr. W. I. Taylor at a Physical Fitness Meeting, Macomb, Illinois. Subject of the talk was "Nutrition and the Relation to Physical Fitness." Dr. James R. Wilson has written an important article on food additives, to appear in the Illinois Medical Journal. The committee chairman contributed an article on the 900 calorie formula diet which appeared in "Chicago Life," Chicago Daily News magazine, September 23, 1961.

The chairman wishes to express his thanks to the other members of the committee for their great cooperation during the past year. The committee as a whole wishes to thank the officers and Council of the Illinois State Medical Society, Mr. Al Boeck, Mr. John Mirt, and other members of the headquarters staff for their great help in making our activities so successful. I'd also like to thank the members of the Council on Foods and Nutrition of the AMA, and the secretary, Philip White and his staff, for their fine cooperation this year.

Paul A. Dailey, G. C. Otrich

Chairman W. I. Taylor

John B. Hall James R. Wilson

Warner H. Newcomb

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION AND SCIENTIFIC SERVICE

This revised committee met July 1961 to discuss the decreasing use of the facilities of the Illinois State Medical Society by downstate counties and districts in their program planning. We determined to obtain a new list of speakers and topics, and to inform the downstate physicians of our desire to furnish excellent speakers on timely medical subjects.

The members of the committee have furnished lists of doctors from institutions they represent who are willing to talk on specific or general subjects. To this nuclei of speakers will be added many others who were on the old, outdated list. The new, revised list of speakers will be cross-indexed as to topics, and perhaps institutions. If kept up-to-date as planned, it should prove invaluable to county medical societies and districts in planning regular monthly meetings or postgraduate courses ranging from one-half to two days,

involving a team of physicians from teaching hospitals or medical schools in Chicago (or St. Louis for southern Illinois).

The chairman met with the councilors in Chicago September 16 and with various Council committees September 17, in a workshop to explain the work and aims of the committee. He also attended the Secretaries' Conference in Springfield October 8, 1961, where he publicized the desire of the committee to aid in their program planning.

On February 26, 1962, four members of the Committee to Evaluate the Work of the Postgraduate Medical Education Committee met with us to discuss our accomplishments thus far and hear our plans for the future. From April 1961 through February 1962, with the splended aid of Mr. Al Boeck and his staff in the Society office, we have furnished individual speakers for 21 different counties, arranged for three postgraduate courses downstate (Marion. Decatur and Lincoln) and will be planning three additional postgraduate courses for the spring and fall of 1962. In addition, 2,701 double postcards, 464 single postcards, and 108 news releases were used to publicize these meetings.

It is our desire to work closely with the councilors, county and district officers to plan excellent programs and to coordinate these meetings to avoid conflicts with other meetings in the areas.

Noel G. Shaw, Ralph Kunstadter
Chairman Harold Laufman
Hubert L. Allen Louis R. Limarzi
Richard Allyn Walter Maddock
Robert J. Freeark George F. O'Brien
Edwin E. Irons J. Mather Pfeiffenberger, Jr.

Leon Jacobson Hyman Zimmerman

COMMITTEE TO STUDY POSTGRADUATE MEDICAL EDUCATION

Because of the illness of the original chairman, the chairmanship of this committee changed in midyear, thus delaying any definitive action on the part of the committee as of the time the annual report was prepared. One formative committee meeting was held in early February, and a joint meeting with the Committee on Medical Education and Scientific Scrvices was scheduled for late February. The

initial activity planned was to discuss the statewide continuing medical education issue with the Illinois Academy of General Practice and the medical schools in the state preparatory to actually formulating the committee's work for the year.

Because of the change of chairmanship, and the late start, no formal report is submitted.

Philip Thomsen,

Chairman

Glen Tomlinson,

Co-chairman

William M. Lees George E. Irwin Hilger P. Jenkins William E. Adams

J. Robert Thompson

COMMITTEE ON RADIATION

Much misinformation appearing in the lay press sometimes brings wrong reactions in both the lay and professional reader.

The Committee on Radiation has sponsored the dissemination of factual information for the members through our official media, the Journal.

On two occasions the chairman of the committee has consulted on an emergency basis with the Department of Public Health, whose responsibility it is to check and control radiation installations throughout the state. This inspection brought to light some hazards in various areas which had to be corrected. In each case the Department of Health handled it quietly and efficiently without embarrassment to the parties involved. Your chairman was able to get quick and effective cooperation by appealing to the councilors in the districts in question.

The function of this committee will continue to be to spread truthful and factual information about radiation hazards, to consult and assist the Department of Public Health in carrying on its duties of inspection and control of radiation installations and sources.

Carl E. Clark,

Chairman

Fred H. Decker

Willard C. Smullen

Earl Barth
J. A. Crilly
Harvey White
Robert Landauer

COMMITTEE ON TUBERCULOSIS

With tuberculosis the number one public health contagious disease problem in Illinois, the committee has devoted its efforts to methods of locating and treating this disease. The committee submits the following:

RECOMMENDATION 1. TB testing should be conducted on a larger scale than in the past; all children under school age should get a TB test annually. Thereafter this should be repeated every four years with the required school physical exam, and the tests continued as a routine procedure in all adult groups as a part of their general physical exams. In any school with a 25 per cent reactor rate, TB testing should be done yearly in all grades and all positive reactors receive an X-ray.

RECOMMENDATION 2. TB testing should be done with the Mantoux test using 5 international units of purified protein derivative or old tuberculin, or using one of the multiple puncture methods.

RECOMMENDATION 3. Every positive reactor should have a chest film taken and read by a radiologist or a chest physician and the results reported to the proper authorities. Such results should also be reported to the family physician, and the family of all positive cases should be tested by a tuberculin test and an X-ray taken if one is indicated. In instances where it is not feasible to carry out this investigation by means of tuberculin testing, the family of all positive cases should be encouraged to at least have an X-ray of their chest.

RECOMMENDATION 4. The importance of a TB test in pre-employment and industrial physical exams should be stressed in an educational program. In these examinations, the skin test is recommended for all persons up to thirty years of age, and an X-ray for those past thirty.

RECOMMENDATION 5. Recent converters to tuberculin among children and young adults should be treated prophylactically by using INH in dosage of 5 mg./Kg. (with a maximum of 10 mg./Kg.) for at least one year. Shorter or interrupted periods of this therapy are to be condemned. The appropriate drug therapy products should be provided by the local tuberculosis authority.

RECOMMENDATION 6. Active therapy should be based on the three principles outlined by the American Thoracic Society as follows:

(a) Combined chemotherapy — the concomitant use of two or more drugs to delay, or to prevent entirely, the emergence of bacterial resistance to any of the drugs used.

- (b) Continuous administration administration of the drugs without a break of more than one or two weeks. This is both a safeguard against relapse and an aid in preventing bacterial resistance.
- (c) Prolonged administration administration for at least a year, usually longer, to prevent relapse.

RECOMMENDATION 7. That emphasis be placed on the importance of initial sanatorium care for active cases to:

- (a) Isolate tuberculosis patients.
- (b) Provide indoctrination of the patient and his family.
- (c) Facilitate institution of adequate therapy at least until the lesion has become stabilized and the sputum converted.

RECOMMENDATION 8. All county medical societies should be asked to approve the principles inherent in the above recommendations and encourage their implementation.

RECOMMENDATION 9. The committee suggests that all physicians avail themselves of *Diagnostic Standards and Classification of Tuberculosis*, published by the National Tuberculosis Association.

RECOMMENDATION 10. X-ray surveys of industries and communities (especially in the high incidence areas) as well as hospital admission x-rays, should be used as the best means possible for the early detection of tuberculosis.

The committee hopes the adoption and implementation of these measures will contribute to the early detection, improved treatment, and ultimate eradication of tuberculosis.

William E. Adams, Chairman George C. Turner James H. Hutton William J. Bryan

Darrell H. Trumpe

Charles K. Petter Frank H. Fowler Clifton F. Hall Charles A. Lang Bernard Klein

COMMITTEE ON LABORATORY EVALUATION

The committee recommends to the Council that the following resolution be submitted to the House of Delegates of the Illinois State Medical Society at the 1962 annual meeting.

WHEREAS: The Illinois State Medical Society and the American Medical Association have

declared the proper conduct of laboratory analyses to be a medical professional responsibility, and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians, and

WHEREAS: There are clinical laboratories in this state which perform such analyses without medical supervision, and whose competence has been questioned, and

Whereas: Such laboratories cannot function without the support of the medical profession, and

Whereas: It is in the public interest that substandard laboratories be brought to a satisfactory level of performance, now therefore

BE IT RESOLVED: That the House of Delegates of the Illinois State Medical Society recommends the formation of a Committee on Laboratory Evaluation in each county medical society and each branch of the Chicago Medical Society; each county society or branch should recommend to its members that they refer patients only to those clinical laboratories evaluated and approved by the local committee on laboratory evaluation. That a Committee on Laboratory Evaluation be maintained in the Illinois State Medical Society, and this committee make periodic recommendations to the county and branch committees on laboratory evaluation concerning the operation of their programs. That the state committee coordinate with the Section on Pathology of the ISMS in support of programs at the state level, designed to raise the standards of laboratory practice in the state.

This resolution is based on the following facts brought out by the committee. At the present time, there is no statutory provision as to the qualifications required to operate a clinical laboratory in this state, and no provision for a control system to provide some assurance of the quality of work performed in clinical laboratories in Illinois. The existing evaluation program of the State Department of Health is on a purely voluntary basis, except that in the case of laboratories desiring to perform serologic tests for syphilis for premarital examinations, participation in the program is mandatory. Illinois and specifically Chicago are the bases of operations of mail-order laboratories indigenous to this area, or which have relocated here after being forced out of an eastern metropolis.

There are grounds to doubt the validity of some of the work done, instances verging on the unlicensed practice of medicine by any definition are known, the flat-fee, "contract" aspects of some services offered are of doubtful propriety. Opinion was approximately equally divided as to whether legislative action should be sought. It was pointed out that certain lay individuals providing clinical laboratory services have wished to sponsor such legislation in the past, and will presumably make other such attempts in the future.

It has been suggested that the solution to these problems might be sought via licensure of clinical laboratories by the state, since it may prove very difficult for each county medical society and each branch of the Chicago Medical Society to evaluate clinical laboratories, to insure that specimens are submitted only to such laboratories, and to police unethical practices. Even if this were to work out as well as it is hoped, it is feared that it would not solve a major part of the problem, namely, advertising by substandard laboratories directly to patients and acceptance of specimens from and reporting directly to patients by laboratories. It has been further suggested that a voluntary program of the type proposed here may permit the kinds of laboratories we feel should be curbed or put out of business to develop further without controls, and that the present situation may deteriorate rapidly.

Your committee believes that the police power of the state need not be invoked to issue permits to laboratories or license individual laboratory workers if the medical profession would accept responsibility for the control of diagnostic laboratories, since

- (a) The physician is already licensed.
- (b) The ethical nature of his acts is subject to review by his colleagues through his county medical society.
- (c) The medical profession holds economic control over diagnostic laboratories, which can function only if patients are referred to them by physicians.

Governmental licensure of diagnostic laboratories or their technical personnel is undesirable, because

- (a) Licensing and review procedures are usually cumbersome and time consuming.
 - (b) The cost of maintaining such activities

constitutes an added burden on state revenues.

- (c) The frequently-included "grandfather clause" may tend to confer legitimate status on the very individuals whose activities have made necessary the development of governmental control procedures, and on those whose qualifications might not permit them to achieve recognition if they were required to meet the same standards as persons applying at a later date.
- (d) Licensure removes the laboratory from direct control by the medical profession, confers an autonomy which may not be appropriate to certain individuals, suggests that diagnostic laboratory examinations are not necessarily a medical function, in contradiction of the resolutions cited above. It constitutes a splintering off of one segment of medical practice, and opens the door to possible future further erosion by other nonphysician groups.

The members of your committee believe that a suggested program for a local committee might include the following:

Laboratories would be approved if they were under the supervision of a physician recognized by his colleagues as having special competence in the field of laboratory medicine, and who would be responsible to the patient and referring physician for the examinations carried out in the laboratory; if the laboratory was adequately equipped for the examinations performed, adequate records maintained, the technical personnel trained in a manner judged adequate by the local committee; if there was evidence of participation in programs of quality control and of continuing education; if there were no unethical practices, including objectionable advertising, division of fees, or referral of specimens to other laboratories without the knowledge and consent of the referring physician. The adoption of such a program would maintain control of medical practice by the profession, would not impose on the State of Illinois the expense of maintaining an additional licensure and evaluation system and would provide a situation of flexibility and responsiveness to local needs by virtue of the local administration of the program.

James B. Hartney,

Chairman
Grant Johnson
Stanley L. Levin

Stanley L. Levin Theodore Z. Polley Jack Williams

Ex-officio:

Franklin D. Yoder Howard J. Shaughnessy

neodore Z. Pollev E. A. Piszczek

Committees Assigned to Director of Legislative Activities

MEDICAL TESTIMONY COMMITTEE

The chairman of the Committee on Medical Testimony participated in the Planning Conference of Committee Chairman on September 17, 1961, at the Drake Hotel in Chicago. At that time there was a discussion with reference to to the role of this committee.

There appeared to be general agreement that the merging of some committees (including this one) might be of benefit to the Society.

Your committee is charged with the responsibility of policing medical testimony and making recommendations for discipline. Fortunately, the committee has had no complaints to process.

Leo P. A. Sweeney, Chairman Harry D. Nesmith John H. Gilmore Maurice D. Murfin Allison L. Burdick Peter Rumore Joseph F. O'Malley L. F. Rockey

MEDICOLEGAL COMMITTEE

Your chairman attended the Planning Conference of Committee Chairmen held in Chicago on Sunday, September 17, 1961, at which time the function and proper operation of committees was discussed. The committee originally furnished legal advice for all members of the Society and legal counsel in case of suit. This was discontinued at the request of the organized bar for the reason that such practice interfered with the lawyer-client relationship and in effect constituted third party law. Since this time, the committee has not had a great amount of work to do. It has conducted a survey to determine how many malpractice suits there were in the state but as with all surveys complete accuracy is difficult to obtain. In 1959, a survey disclosed that in downstate Illinois, with the exception of three or four counties, there were practically no suits.

At the conference, the suggestion was made that the Medicolegal Committee, the Medical Testimony Committee, the Committee on Impartial Medical Testimony, the Liaison Committee to the Illinois State Bar Association, the Narcotics Committee and the Committee on Forensic Medicine might possibly be combined. The work of all of these committees could be assigned to the resulting committee which would have subcommittees retaining the present personnel assigned to each of these fields. The chairman of the parent committee would then be in a position to coordinate the activities of all of these committees and prevent duplication or overlapping functions. The suggestion seemed to meet approval of those in attendance.

The committee presently has under consideration a suggestion made by the General Counsel that the committee should compile a notebook of medicolegal material, including the Interprofessional Code of Conduct for lawyers and physicians which could be added to from time to time, as new legal decisions are rendered or problems arise. The notebook could contain all materials which would be of help to the physician in meeting medicolegal problems in his practice. An example would be a discussion of procedures necessary to obtain a commitment of a mentally ill person including forms, etc. A charge could be made for the notebook but all materials would be furnished frec of charge to the subscribers as they were issued.

George C. Turner,

Chairman

Charles Allison

Leo P. A. Sweeney

F. E. Bihss Edward C. Helfers Ralph McReynolds

COMMITTEE ON MEDICAL SERVICE

Your committee has had an extremely busy year. As you may recall, the Society experienced another highly successful legislative year in the 72nd General Assembly, which ended on July 1, 1961. Nine pieces of legislation offered by the Society were all approved by the legislature. Those approved by the Governor included S.B. 197, the \$20,000,000 program of medical care to the aged based on the Kerr-Mills matching program. This is now known as the Aid to the Medically Indigent Aged program.

Other laws enacted include S.B. 320 which protects the confidentiality of records of tissue

committees of hospitals and research projects of ISMS and the State Department of Public Health. Another law enacted is one which permits certain minor persons to consent to emergency medical or surgical procedures. The Medical Practice Act was strengthened in various respects, one of which permits the Department of Registration & Education to revoke or suspend a license for unethical conduct of a nature likely to deceive or defraud the public. Heretofore, a license could only be revoked where there was a conviction of a crime specified in the Act. S.B. 778 which would have created medical corporations to take advantage of the so-called Kintner decision in respect to deferment of income in retirement plans for tax purposes was vetoed by the Governor who preferred S.B. 804, the professional association approach to the same prob-

The Medical Practice Act Commission, originally set up to study osteopathic problems, having served its original purpose, was opposed by the Society and it was not reconstituted. The qualifications for the Director of the Department of Public Health were rewritten at the suggestion of the Society. A number of bills were opposed and all were defeated through the activities of the Society. These included such bills as H.B. 1577, which would have regulated disciplinary proceedings of voluntary associations and professional groups.

Hearings were held on H.R. 4222, the socalled King-Anderson bill, by the House Ways & Means Committee during 1961 but the Congress adjourned without taking action. The new session of Congress convened on January 10, 1962, amid strong pressures mounting for passage of this medical care to the aged bill geared to the social security mechanism. The administration has vowed an all-out fight for this foot-in-the-door approach to control over the dispensing of medical care. Your committee and the entire resources of the Springfield office, plus support from the Chicago office has been thrown into this fight, to keep the medical profession free. In addition, the AMA has made available the services of a field man, who will work in special areas. In an effort to improve communications and to set up a grass-roots committee of physicians charged with cultivating the congressmen, your committee approved the formation of congressional committees of physicians in each congressional district. While this mechanism is new and we understand it is one of the first, if not the first in the country, the committee apparatus as a whole has functioned well.

Your committee feels that as a result of contacts made with congressmen, we have been able to improve our relationship with members of Congress. Your committee attended the AMA National Legislative Conference held in Chicago on January 26 and 27, a highly informative program, and a useful tool in our legislative program. In order to motivate and help society members in the King-Anderson campaign, your committee held its Sixth Annual Legislative Conference in Chicago on January 27. We believe it will prove helpful and useful in our fight against this threat to the freedom of the profession. In addition, representatives of the committee attended the U.S. Chamber of Commerce Public Affairs Conference in Washington, D. C., on January 24 and 25, at which time we received a briefing on the make-up and probable issues expected to be encountered in this session of Congress. The Society held a reception for members of the Illinois Congressional delegation on the evening of January 23. The Springfield Newsletter, written by our General Counsel, was continued and is proving to be extremely informative and helpful on all legislative matters affecting the medical profession. We have received many favorable comments concerning it this year. In addition, our General Counsel has endeavored to keep and retain the interest of physician members of the new Congressional Committees through periodic publication of a new publication of limited circulation, the Congressional Bulletin.

The threat to the freedom of the profession, and in fact to all those who dispense personal service was never greater than at present. The King-Anderson bill is but the beginning of a complete cradle-to-the-grave system of government dispensed medical care and can be used as a precedent to control all those who dispense personal services in this country. As such, it meets the definition of socialism, to-wit, "a system of production for public use and not private incentive to the end that each shall contribute according to his means and each

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shall receive according to his needs." Whether you recognize this threat as socialism or not is not so important so long as each and every physician realizes that the King-Anderson bill represents a threat to his integrity as a physician; that what is involved is governmental control over who shall practice medicine, how he shall practice, who his patients shall be, and how much he shall be paid. Justice Jackson said, "It is hardly lack of due process for the Government to regulate that which it subsidizes." Let us all resolve to fight off this threat to our freedom.

Richard J. Bennett, *Chairman* Ralph N. Redmond J. Ernest Breed V. P. Siegel George B. Callahan Edwin S. Hamilton Jacob E. Reisch

COMMITTEE ON FORENSIC MEDICINE

A meeting of the Committee on Forensic Medicine was scheduled for Friday, January 26, 1962, at the Sheraton-Chicago Hotel. Drs. Bauer, Jannings and Hirsch came at the appointed time, but because of some confusion and delay in establishing the room, the committee members did not assemble.

The purpose of the meeting was to acquaint the members of the committee and to receive their comments on the progress which is being made in Cook County under Coroner Andrew J. Toman, M.D., in rebuilding the Cook County Hospital morgue into an institute of forensic pathology for the coroner. Much background planning and implementation of this program occurred under the preceding coroner through the Active Citizens Advisory Committee to the Coroner. Revision of the Cook County Hospital morgue was started in the summer of 1961, and is in the first of two phases of construction.

The first phase is the construction in the basement area of eight separate walk-in crypts, each with a capacity of sixteen to twenty bodies for storage; three autopsy rooms each with two autopsy tables for ordinary purposes; another crypt with a capacity of twelve to fifteen for decomposed bodies, and a fourth autopsy room for these examinations; an X-ray unit; and facilities for police and missing persons units. Extensive revisions of the inquest rooms and offices on the first floor and some of

the laboratories on the second floor are in this phase of construction.

When, in about two years the new laboratory building for Cook County Hospital now in construction on the east side of Wood Street is completed, the second phase in the reconstruction of the morgue building will complete the entire second floor for pathology, and the third floor for toxicology. This development with personnel organization will give Chicago and Cook County outstanding facilities in forensic pathology.

One of the two laboratories for the downstate coroners provided through an appropriation of \$200,000.00 by the 71st General Assembly has been established in the branch laboratory of the State Department of Public Health at 1800 West Filmore Street, Chicago. This is in limited functional service. Medicine in Chicago and in Illinois can be proud of this progress in improving the quality of the medical examinations for the county coroners.

Edwin F. Hirsch,

Chairman

Samuel A. Levinson

Dennis B. Dorsey

Frederick C. Bauer, Jr.

Grant Johnson

C. J. Jannings

LIAISON, ILLINOIS BAR ASSOCIATION

This committee, meeting with a similar committee from the Illinois Bar Association, proposed an Interprofessional Code for the medical and legal professions. This code was submitted to the Illinois State Medical Society House of Delegates and to the Illinois Bar Association and these respective bodies have approved this action. The code has been published in the Illinois Bar Journal and in the Illinois Medical Journal and is now binding upon the two professions.

The Interprofessional Code calls attention to the members of each profession that there is an obligation to the individual who obtained their advice and also to the community and society as a whole, as well as to the other members of their respective professions.

At the present time, your committee is meeting with a similar committee from the Illinois Bar Association discussing the subject of a medicolegal plan for screening medical malpractice cases. The purpose of this plan is to prevent the filing of unfounded malpractice

suits and to facilitate the fair and equitable disposition of such claims. After thorough study and agreement, this will no doubt have to be referred to our Medicolegal and Medical Testimony committees for their opinions.

Throughout the year this committee has continued to serve as a line of communication between these two great professions. Through this communications line, both the members of the legal and medical professions are being educated as to third party practice. Such exchange enables these two groups to present a consolidated position on this subject.

Your chairman is most grateful to members of the liaison committees, the officers and members of the Council, the executive administrator and particularly the staff advisor, Mr. Oblinger. Newton DuPuy,

Leonard R. Smith

Chairman
William E. Adams

Kenneth C. Johnston George H. Woodruff

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY

The following report is one of progress and a continuation of the annual report published for 1960 in the Illinois Medical Journal.

The Illinois State Supreme Court has adopted Rule 17-2, putting into effect Impartial Medical Testimony (nonpartisan medical witness) for the Superior and Circuit Courts for the State of Illinois. This rule officially was placed in operation September 5, 1961. This is the first state in our Union where Impartial Medical Testimony has been put into operation on a statewide basis and the first state where this rule has been initiated by the medical profession.

Impartial Medical Testimony has been in operation for two years in the Northern Illinois Federal District Court. Seventy-six cases were handled by the Northern Illinois Federal District Court, calling upon 94 doctors from the panel of the Illinois State Medical Society. Since Impartial Medical Testimony used by the court is primarily for pretrial hearing, and primarily in personal injury cases, 38 of the 76 cases have been resolved at pretrial hearing, several are in the process of study by the court, and approximately 6 cases have been called for active trial hearing. The judges of the Northern Illinois Federal District court are most pleased with the operation of this pro-

gram, and Impartial Medical Testimony is one agent to help reduce the tremendous backlog of cases in our courts.

The panel of experts made available to the courts in Cook County has been in existence for a considerable period of time. The Committee on Impartial Medical Testimony is now in the process of establishing a similar panel of specialists in the various specialties in medicine for 101 counties outside of Cook County. As of this moment the panel on orthopedic surgeons, neurologists, and neurosurgeons is available to the entire State of Illinois. The panel of specialists in the other areas is being studied carefully now and will be made available for the court administrator in Springfield and the deputy court administrator for Cook County in a very short time.

In order to implement the operation of this program for the next two years, the Illinois State Medical Society has made contact with various foundations in the United States for support of this program. It has been estimated by the Illinois Supreme Court that \$40,000 should defray the medical expenses for specialists for the following two years. The Ford Foundation has allocated \$25,000 toward this program and the Illinois State Medical Society is now in the process of making contacts with various agencies for \$15,000 to match on a \$3 for 2 basis the contribution made by the Ford Foundation. This contribution of funds is placed with the Illinois State Bar Association Foundation, and every doctor who is called upon as a nonpartisan witness to examine the patient and the records, either from the hospital or from the physicians attending the patient, will be compensated from these funds approved of by the judge at the request of the court administrator.

We solicit the cooperation of the medical profession in the State of Illinois to support this program for the medical truth in the court and for justice for the plaintiff and defense in personal injury cases. This program will again be re-evaluated at the end of the two year experimental period from 1961-1963, and if successful the courts will include in their budget funds to continue the program of nonpartisan medical testimony for the courts in the State of Illinois. This is a worthwhile contribution by the medical profession of the State of Illinois

for its citizens to support medical truth, justice for the citizens in our state, and for the continuation of social and education progress for the citizens of our state.

Several editorials and articles pertaining to Impartial Medical Testimony have been written by members of our committee and published in various journals.

Members of our committee have had several meetings with members of The Panel on Nonpartisan Medical Witness, and with members of the court concerning the procedures of Impartial Medical Testimony.

Samuel A. Levinson, Ken Roper Chairman V. P. Siegel Newton DuPuy John Condon Percy E. Hopkins Warren Young Aaron Kanter Roger Harvey Norman Roberg Ex-officio: Clinton Compere Edwin S. Hamilton Roland Mackay George F. Lull Harold Voris E. A. Piszczek

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES

Early this year the committee was concerned with a study of a rehabilitation plan proposed by the Chicago Junior Chamber of Commerce and Industry. Your chairman appeared before the Council and communicated the committee's recommendation for approval, which was granted.

Currently, the junior association is considering an application to the National Institute of Mental Health for a grant. That organization has requested the Society's Educational and Scientific Foundation to act as fiscal agent to receive and disburse funds and to perform certain administrative functions. This matter is under study and a report will be made to the Council with the committee's recommendations.

The office of the State Division of Narcotics Control has furnished speakers to many lay and professional groups and the committee is pleased that citizens of our state are better informed than ever before relative to the narcotic problem and its progressively improved management.

Lee N. Hamm. George S. Schwerin Earl H. Blair Chairman William U. McReynolds

COMMITTEE ON OCCUPATIONAL HEALTH

This committee has been quite active during the latter part of 1961 in meeting with the entire Industrial Commission to discuss presentday problems. Three of the commissioners and ten of the arbitrators have been replaced by lawyers through appointment by Governor Kerner.

We were able to make arrangements to furnish Mr. Albert G. Scheele, secretary of the Industrial Commission, with outstanding specialists in orthopedics, cardiology, neurology, psychiatry and neurosurgery for an entire week. An entire week of afternoon seminars for all Industrial Commission members was attended by the commissioners and 14 arbitrators.

In February, arrangements were almost completed to have a medical director of a large corporation discuss the latest development of fringe benefits, including hospitalization, surgery fees, insurance, etc., and the impact that these items have on the practice of medicine. In March, we are having Mr. Scheele, secretary of the Industrial Commission, tell of the advances and improvement which have been made in the filing, hearing and arbitration of cases. In April we plan to have the secretary of Occupational Health of the AMA talk on the present status of occupational health in the United States.

Richard J. Bennett, V. P. Siegel Clarence F. Kelly Chairman Myron J. Tremaine B. Dixon Holland Milton H. Kronenberg Eugene L. Walsh Fred Stansbury Arthur Petersen O. W. Rest

AD HOC COMMITTEE ON THE SPRINGFIELD OFFICE

During 1961, your Society negotiated a lease for approximately 1600 square feet of space on the second floor of the building at 520 S. 6th Street in Springfield. The initial rent is \$2.25 per square foot, with all services furnished, including air conditioning. We have an option to renew at the end of the second year for an additional period of 3 years with rental set at \$2.40 for the fourth and fifth years.

The owner has agreed to remodel the front of the building and he has submitted plans for erecting a colonial facade. It is hoped that this can be accomplished within the coming year.

It is the opinion of your committee that we have adequate space at this location and the rental appears to be reasonable. The space is sufficiently large to get the volume of work done that needs to be done in the Springfield office. Until such time as the learned professions jointly want to erect a Springfield office building, it would appear that our needs are being taken care of adequately and properly. In fact, the committee feels that our present

arrangements are probably the least expensive that can be found without engaging in a great capital improvements program.

The office has been efficiently laid out and has the needed machinery and equipment, sufficient unto its needs. The personnel appear to be happy with the physical arrangements. There is a conference room for committee meetings. We invite the membership to drop by and inspect the facilities. There is parking in the rear of the building.

Harlan English, Harry Mantz

Chairman Jacob E. Reisch

Resolutions

RESOLUTION NO. 62-1

Introduced by: Madison County Medical

Society

Subject: Fees paid by a third party Reference Committee #3.

Whereas, fees paid to physicians by the Illinois Public Aid Commision (IPAC), including Old Age Assistance (OAA), Aid to Dependent Children (ADC), Aid to the Disabled (AD), Aid to the Blind (AB), and Assistance to the Medically Indigent Aged (AMIA), and MEDICARE, appear often outmoded, discriminating and in some cases do not even meet the cost of providing such services — a discount not expected of any other vendor of services in these third party transactions, and

Whereas, the forms in use by these programs are unnecessarily numerous, complicated and redundant, and drawn up without any apparent consideration of the physician's time limitations, and

Whereas, at its special session on October 29, 1961, the Illinois State Medical Society agreed that the base for AMIA services needed and rendered be, quote, "Realistic," a formula to which all could agree;

Now therefore be it resolved, that if the fee paid by a third party is to be considered complete compensation for services rendered, it shall conform to the usual prevailing charge for such services in the area; and

BE IT FURTHER RESOLVED, that all fees and forms used shall be subject to effective arbitration and appeal by either party.

RESOLUTION NO. 62-2

Introduced by: Lee County Medical Society
Subject: Interprofessional Council
Reference Committee #2.

Whereas, the Interprofessional Committee of the Illinois State Medical Society has been making a study of the Michigan Association of Professions, and expects to report progress to the House of Delegates, and

Whereas, the Illinois State Medical Society has been a participating member of the Illinois Interprofessional Council for the past few years, and

Whereas, the organization of the Illinois Association of Professions would include representation from architecture, dentistry, engineering, veterinary medicine, law, medicine and pharmacy as charter member organizations,

Now THEREFORE BE IT RESOLVED, that the need for continued membership in the Illinois Interprofessional Council no longer exists, and

BE IT FURTHER RESOLVED, that the Illinois State Medical Society withdraw as a member of the Illinois Interprofessional Council.

RESOLUTION NO. 62-3

Introduced by: Jackson County Medical Society

Subject: Accreditation of Hospitals Reference Committee #4.

Whereas, complete approval by the Joint Commission on Accreditation of Hospitals has

become an economic necessity for the hospitals of Jackson County, and

Whereas, the American Medical Association is a member of the Joint Commission and the Jackson County Medical Society is represented by delegates of the Illinois State Medical Society,

Now THEREFORE BE IT RESOLVED, that the Jackson County Medical Society requests through the delegates of the Illinois State Medical Society that the American Medical Association insist upon a protective and appeal procedure prior to the withdrawal of accreditation of any previously accredited hospital; and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent immediately to each member of the Jackson County Medical Society; and

BE IT FURTHER RESOLVED, that the delegates from the Jackson County Medical Society be instructed to present this resolution to the House of Delegates at the May 1962 meeting of the Illinois State Medical Society.

RESOLUTION NO. 62-4

Introduced by: Marion County Medical

Society

Subject: Project Hope

Reference Committee #7.

Whereas, Project Hope of the People to People Medical Foundation is bringing medical care and medical teaching by American physicians and surgeons around the globe, and

Whereas, Project Hope in carrying out this mission is promoting friendship and understanding between the nations of the world and our own United States of America, and

Whereas, vast areas on the globe are in dire need of medical help and medical teaching as it is exercised by the technical and professional people connected with Project Hope, and

WHEREAS, the recent year long mission of the SS Hope in Indonesia and in South Viet Nam has been highly successful from a medical standpoint, as well as from an international friendly relation standpoint, and

Whereas, one of the members of the Marion County Medical Society was privileged to serve as a volunteer for Project Hope in Indonesia during 1961, and

WHEREAS, further trips of the SS Hope into

other parts of the world are contemplated, and

WHEREAS, Project Hope is carrying out and considering land based operations in other parts of the world, and

Whereas, Project Hope is relying solely on the private support of its mission,

Now THEREFORE BE IT RESOLVED, that the Marion County Medical Society endorses the objects of Project Hope of the People to People Medical Foundation, and

BE IT FURTHER RESOLVED, that the Marion County Medical Society urges its members, as well as the general lay population, to give Project Hope its full moral and its full financial support to enable Project Hope to carry out its missions successfully and to continue its work in the interest of mankind, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the Illinois State Medical Society with the suggestion that the Illinois State Medical Society may approve a similar resolution at its next annual meeting.

RESOLUTION NO. 62-5

INTRODUCED BY: Walter C. Bornemeier

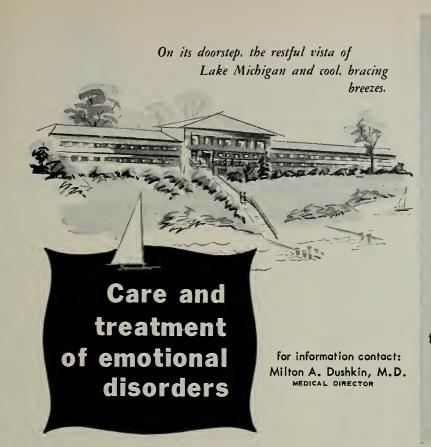
Subject: Recognition of physicians working on programs in foreign countries

Reference Committee #7.

RESOLVED, that the House of Delegates of the Illinois State Medical Society approve the following resolution to be submitted to the House of Delegates of the American Medical Association:

Whereas, many physicians in the United States have given, and are giving, of their time and talent by serving without pay for various periods of time in an organized effort (such as Project Hope, Focus, etc.), which renders medical care to the needy of other lands,

Now therefore be it resolved, that the speaker of the House of Delegates of the American Medical Association appoint a committee to determine who, from our membership, has given time and talent without remuneration to organizations rendering medical care in foreign countries during the past decade, and to prepare a suitable resolution honoring these physicians as soon as possible.





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loca-Cola, too, is compatible with a well balanced diet.

As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.



NEWS and ANNOUNCEMENTS



Cook County

Awards

Three area medical students have been selected for fellowships from the Association of American Medical Colleges for study in underdeveloped countries to provide clinical medical experience from other cultures.

The students are Benjamin H. Alexander, Northwestern University Medical School — The Philippines; Ned N. Cowan, University of Illinois College of Medicine — Tanganyika; and Robert D. Woodson, University of Chicago School of Medicine — Ethiopia.

The scholarships, from a \$60,000 yearly grant by Smith Kline & French Laboratories, were awarded to 33 junior and senior medical students throughout the country.

Election

Nathan W. Helman, director of Mount Sinai Hospital for the past five years, and associated with the institution since 1928, has been elected executive vice president. Named administrator was Manuel Cohen, former administrator of Mount Sinai Hospital in Milwaukee.

N.U. Speech Clinic Moves to Evanston

Northwestern University's department of communicative disorders moved to the new Speech Clinic Building on the Evanston campus in March. The refurbished four-story building has the latest in modern facilities, including sound-treated cubicles, more observation rooms, listening, teaching and research laboratories, and a parking lot with ramps to accommodate wheel chairs. The new building will also house the Cerebral Palsy Clinic.

Appointment

Dr. Nat E. Smith, assistant professor of medicine, University of Illinois College of Medicine, has been appointed to the newly created post of assistant dean of medicine.



REMINDER: E. A. Piszczek, M.D., chairman of the Council, ISMS, points to the date of the First Annual AMA Bowling Tournament which will be held in Chicago during the 1962 meeting of the AMA and hosted by the ISMS. Pictured left is Mr. Jerry Behrstock, manager, Chicago Branch — North, of the Brunswick Corporation, and right is Mr. Bruce Shafter, manager, Orchard Twin Bowl, Skokie, where the tournament will be held.

Macon County

Doctor's Emergency Service

The county medical society has put into operation a Doctor's Emergency Service providing a day and night telephone number, 423-3603, for persons unable to reach their own physician. The service will aid in locating the physician or his authorized substitutes.

Winnebago County

Novel Publicity for March Meeting



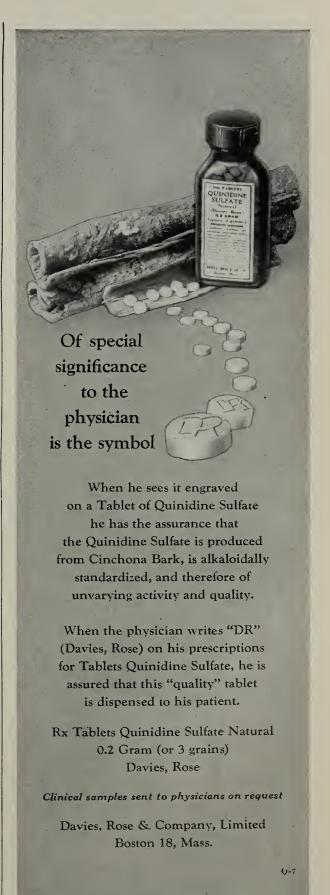
WE'VE GOT TO GET HIM OFF OUR BACK!

This imaginative cartoon flyer was used by the Winnebago County Medical Society to remind members that the King-Anderson Bill was to be discussed at the March 14 meeting.

Judging from the turnout of 85 society members and guests, the unique publicity release served its purpose with unqualified success.

Bettering Public School Health Education

The School Health Education Study, established in September 1961, will embark on a two-phase program for 1961-62 to improve



health education in the public schools of the United States. Sponsored by the Samuel Bronfman Foundation of New York City, the study is being conducted in cooperation with the American Association for Health, Physical Education, and Recreation, a department of the National Education Association.

It will begin with a survey of health instruction practices in large, medium and small school districts in the U. S. Existing tests will then be administered to sample groups of students in the sixth, ninth and twelfth grades to measure the extent of their health knowledge and understanding. The first report should be available late in 1962.

Dr. John L. Reichert, Chicago, is a member of the eight-member Advisory Committee for the study. Dr. Reichert is chairman of the Illinois State Medical Society's Committee on Child Health.

Land for Clinic Site Donated

The Macon County Mental Health Association has donated 89.6 acres north of Decatur,

formerly part of the Macon County farm, to the State of Illinois for construction of a community-centered mental health clinic. Funds to purchase the clinic site, in Zone 6, were donated by residents of Macon county.

-ANNOUNCEMENTS-

PG Courses

The spring postgraduate courses offered by the American College of Physicians, begun in March, continue with "Fundamentals and Applied Aspects of Cardiology," May 14-16, at the Wayne State University College of Medicine, Detroit.

Subsequent courses will be "The Neurology of Diseases of Internal Medicine," May 21-25, at the Harvard Medical School, Boston, and "Psychiatry for the Internist," June 4-8, at the Psychiatric Institute, University of Maryland School of Medicine, Baltimore.

Full details may be obtained from the College, 4200 Pine St., Philadelphia 4.

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Superior nursing care.

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Woman's Auxiliary Annual Meeting

An invitation is extended to all physicians' wives and their guests to attend the annual meeting of the Woman's Auxiliary to the Illinois State Medical Society, May 15-17, in the Sherman House. The annual dinner for past state auxiliary presidents will be held on May 15 and the installation luncheon for the incoming president on May 17, in addition to daily delegate and other business sessions.

Social functions will include an open house, theatre party, and a luncheon and fashion show.

The meeting is planned to bring those attending up-to-date with the Auxiliary's objectives and inform them of progress made toward these goals.

National Disaster Training for Citizens

Plans are under way to launch a Medical Self-Help Training Program in Illinois to teach residents how to render self-help medical care in the event of a national emergency. Developed and sponsored by the American Medical Association and U. S. Public Health Service, the program will be administered in Illinois by the Department of Public Health, in cooperation with the Illinois State Medical Society, the Illinois Civil Defense Agency and the Office of Public Instruction.

The ten counties selected for the pilot project are: Adams, DuPage, Franklin, Jackson, Lake, Lawrence, Peoria, Rock Island, St. Clair and Sangamon.

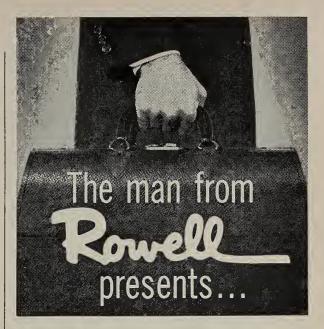
Special training kits will be used in the course, which consists of 12 lessons, plus a supplementary movie, and usually requires about 16 hours to complete.

Jottings

The physicians in Washington State are inviting doctors who plan to visit the Seattle World's Fair to coincide their trip with the Washington State Medical Association's annual meeting in Spokane, September 16-19. The Fair runs from April 21 to October 21.

The association's scientific program is composed of specialty meetings, general sessions and medical television.

For additional information and hotel res-



RO-SULFA

A new combination of sulfonamides for urinary tract infection. Sulfamethylthiadiazole (SMTD) with trisulfapyrimidines (TRES SULFA, ROWELL) provides a broad antibacterial spectrum with rapid, high urinary levels for local effect and high, lasting blood and tissue levels for systemic effect. Combining four sulfonamides allows low individual levels for greatly reduced crystalluria. Phenylazo-diaminopyridine contributes a potent urinary tract analgesic for symptomatic relief.

Indications: Upper and lower urinary tract infections amenable to sulfas; prophylaxis in surgery, instrumentation, catheterization, urinary stasis, etc.

EACH COATED TABLET CONTAINS:

Sulfamethylthiadiazole TRES SULFA*	
Phenylazo-diaminopyridine HC1	
*Rowell's brand of trisulfapyrimidines (equal of sulfadiazine, sulfamerazine and sulfameth	l amounts azine).

Side Effects and Contraindications: As with all sulfas, watch for crystalluria, though this is minimized by Ro-Sulfa formula. Discontinue if exanthemata, urticaria, fever, hematuria, etc., occur. Contraindicated in hypersensitivity to sulfas, chronic glomerulonephritis, pyelonephritis of pregnancy, hepatitis and uremia.

VIO-SAL

A combination of buffered salicylates and Vitamin K providing analgesic, antipyretic and anti-inflammatory actions for relief of pain and discomfort arising from arthritis, rheumatism and rheumatic fever. Contains Vitamin K (menadione) to guard against the hypoprothrombinemia sometimes associated with intensive salicylate therapy. Vio-Sal is effectively buffered and sodium-free.

EACH BUFFERED TABLET CONTAINS:

Potassium Salicylate	150 mg.
Strontium Salicylate	150 mg.
Calcium Salicylate	150 mg.
Vitamin K (menadione)	

For more facts, see your local Rowell man, or write:



ervations in Spokane and Seattle, contact the Association at 1309 Seventh Ave., Seattle.

The problems of the doctor and nurse in handling premature infants in a hospital without a center will be discussed Wednesday, April 25, at Little Company of Mary Hospital, Evergreen Park. The one-day Seminar on Premature Care is free; preregistration is required.

The annual meeting of the American College of Chest Physicians will take place in Chicago, June 21-25, at the Morrison Hotel. Contact the College at 112 E. Chestnut St., Chicago 11, for further information.

Speech Disorder Centers Merge

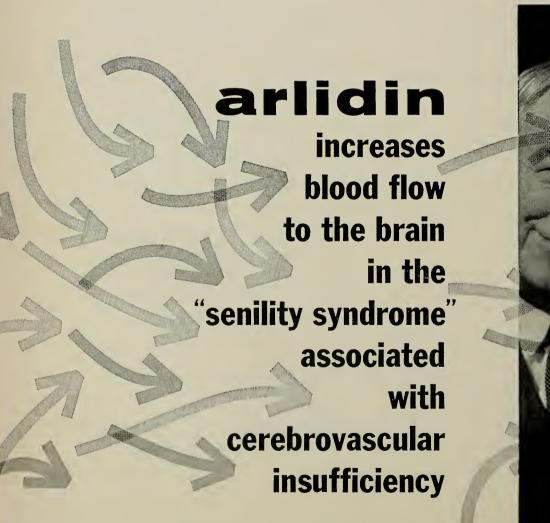
Affiliation of DePaul University's Institute for Special Education with the Dr. Robert Henner Hearing and Speech Center of Michael Reese Hospital was announced in February. Members of the Michael Reese staff will hold academic appointments at DePaul, and faculty members of the Institute will hold appointments as consultants to the Center. The merger is intended to give clinical experience to students studying communicative disorders.

Deaths

Paul F. Brown*, retired, Maywood, a graduate of the University of Minnesota Medical School in 1905, died February 11, aged 84. In 1947 he retired as chief of professional services at Hines Hospital. He was a member of the 50-Year Club of the Illinois State Medical Society and a World War I veteran.

Otto H. Deichmann, retired, Virginia, Ill., a graduate of Washington University School of Medicine in 1902, died February 10, aged 81. He retired in 1954.

Ethan A. Gray*, retired, Pentwater, Mich., a graduate of Rush Medical School in 1887, died January 23, aged 97. He had practiced in Chicago until his 1933 retirement and was a





member of the 50-Year Club of the ISMS and emeritus member of the Society. In 1926 he was named president of the Mississippi Valley Conference on Tuberculosis and from 1916 to 1924 was assistant professor of medicine at Northwestern University Medical School. He also was a former president of the Chicago Tuberculosis Institute and of the Chicago Fresh Air Hospital.

Lilburn S. Greenwood*, Rockford, a graduate of the University of Illinois College of Medicine in 1929, died January 14, aged 59. He had practiced several decades in Rockford.

Elfriede P. Hesse*, Chicago, a graduate of Friedrich-Wilhelms-Universitat Medizinische Fakultat, Berlin, in 1921, died January 29, aged 67. She was associated with the Mental Health Division of Cook County Hospital.

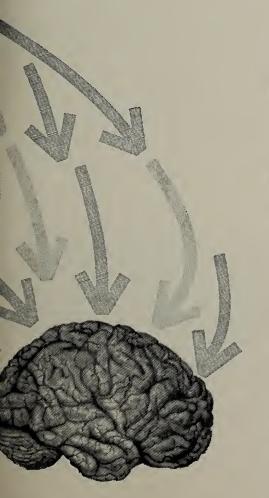
Edwin R. Hobson*, Gillespie, a graduate of Northwestern University Medical School in 1927, died January 26, aged 61.

Joseph F. Konopa*, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1916, died January 29, aged 66. A staff member at St. Mary of Nazareth Hospital, he belonged to the Polish Medical Society.

Oscar H. Kraft*, retired, Deland, Fla., a graduate of the University of Buffalo School of Medicine in 1896, died February 20, aged 89. He had lived in Florida since his retirement in 1951 after 50 years of Chicago practice. Before retiring he had been on the staffs of Grant, Alexian Brothers, and Illinois Masonic hospitals. An emeritus member of the Illinois State Medical Society, he also belonged to its 50-Year Club.

John W. McLaughlin*, Cedar Rapids, Iowa, a graduate of the Chicago College of Medicine and Surgery in 1916, died December 22, aged 78. He was an emeritus member of the ISMS.

Jacob H. Nemeroff*, Chicago, a graduate of the University of Illinois College of Medicine in 1922, died October 26, aged 64. A Chicago physician 40 years, he was on the staff at Grant Hospital.



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.¹⁻³

43% increase in cerebral blood flow with Arlidin

In patients with cerebrovascular insufficiency, Eisenberg⁴ measured a 43 percent increase in blood flow in the brain following administration of Arlidin orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

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Arlidin is a unique and dynamic vasodilator which acts to increase circulation in the brain...in the inner ear and eye...also in the peripheral skeletal muscle.



references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

NOTE — before prescribing ARLIDIN the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc. Write for complete detailed literature.

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Aurelio Pagano*, retired, Italy, a graduate of the Universita di Napoli Facotta di Medicine e Chirurgia in 1906, died October 16, aged 81. He had lived in Ricigliano, Italy, since his retirement in 1960 after 53 years of practice in Chicago. A member of the 50-Year Club of the ISMS, he also had emeritus membership in the Society.

Samuel M. Robin, retired, Chicago, a graduate of the University of Illinois College of Medicine in 1906, died February 17, aged 78. He was a south side physician for more than 50 years prior to retiring three years ago. From 1918 to 1949 he was on the Chicago board of health and from 1925 to 1950 was a physician for the Chicago public schools. Dr. Robin served with the U. S. Army Medical Corps in World War I and was a past president of Adolph Kraus Chapter, B'nai B'rith.

John F. Ross*, Quincy, a graduate of Washington University School of Medicine in 1906, died February 8, aged 78. An Adams County physician 56 years, he was a former president of the county medical society. He was on the staffs at Blessing and St. Mary's hospitals, Quincy, and had been a trustee of Hillcrest Sanatorium since 1948. Dr. Ross belonged to the Illinois State Society's 50-Year Club and was a fellow of the American College of Surgeons and a 32nd degree Mason.

Irwin J. Scheer*, Chicago, a graduate of the Chicago Medical School in 1938, died October 13, aged 55. He had practiced 25 years and was on the staffs at Belmont Community and Columbus hospitals. He was a member of the American Society of Abdominal Surgeons.

Homer A. Seymour*, retired, Hillsboro, a graduate of Eclectic Medical College, Cincin-

nati, in 1894, died January 23, aged 89. A 50-Year Club member and emeritus member of the ISMS, he retired in 1953 after 59 years of practice in Hillsboro. He served on the town high school board from 1919 to 1942, being president from 1924 until the end of his service. In World War I he was on the Montgomery County Selective Service Board. He had emeritus membership in the ISMS and belonged to its 50-Year Club.

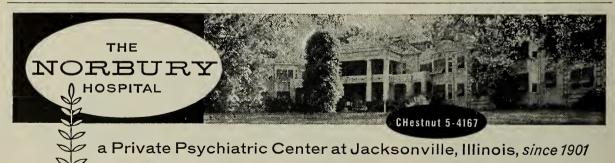
Morris F. Stein*, Chicago, a graduate of Northwestern University Medical School in 1926, died January 24, aged 60. He had been in practice 35 years and was a staff member at Belmont and Northwest hospitals.

Wayne R. Walker*, retired, Pekin, a graduate of Loyola University School of Medicine in 1927, died February 11, aged 64. He was a past president of the medical staff at Pekin Memorial Hospital and a staff member at St. Francis Hospital, Peoria, and St. Joseph Hospital, Bloomington. Memberships included the American Cancer Society, American College of General Practitioners, the Polio Foundation, and the Heart Foundation.

Carl H. Wilkinson*, West Lafayette, Ind., a graduate of the Chicago College of Medicine and Surgery in 1904, died December 20, aged 91. An emeritus member of the Illinois State Medical Society, he belonged to its 50-Year Club.

Lyman D. Wright*, retired, Rochester, a graduate of the St. Louis University School of Medicine in 1902, died January 2, aged 80. He retired in 1955 and was an emeritus member of the Illinois State Medical Society and belonged to the Society's 50-Year Club.

*Indicates member of Illinois State Medical Society.



Complete psychiatric treatment in an environment for cure. A 75 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

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"Hour for Action" is Now

AMA Schedules National TV Time May 21 on King-Anderson

AMA is planning to counter the Kennedy Administration's national TV program of May 20 by a program of its own. This program will be carried over the NBC-TV network on Monday, May 21, from 7:00 to 7:30 p.m., Central Daylight Saving Time. The format is not known at present but it will be designed to correct any misstatements of fact by the Administration and will present medicine's point of view on the King-Anderson compulsory medical care program.

Extent of Administration's Pressure Campaign Becoming Known

The extent of the Administration's nationwide appeal for support of the King-Anderson Bill is now becoming known. On Sunday night, May 20, the President will address a rally of 20,000 senior citizens in Madison Square Garden. This meeting will be held under the sponsorship of the National Council for Senior Citizens and will be carried nationwide over radio and TV. The CBS-TV network will televise this speech from 10:15 to 10:45 p.m., Central Daylight Savings Time, and over CBS Radio from 7:30 to 8:00 p.m., Central Daylight Savings Time. The President is expected to produce a list of 50,000 names gathered from older persons who allegedly have written letters stating that they suffer from lack of medical care because of financial (Continued on next page)

SPECIAL COVER FOR MAY

Due to the urgent requirement for every physician to write a "vote no on King-Anderson" letter to his Congressman, a cartoon reminder replaces our standard cover for the May issue only. This original cartoon was designed and drawn especially for the Illinois Medical Journal by Don Holland, editorial staff cartoonist for the Chicago Tribune.

hardship. He is also expected to be presented with a petition of close to one million names of people who want King-Anderson enacted. At the same time this meeting is being held in New York City similar local meetings have been scheduled in 20 major cities around the country. The President's presentation will be sent to these meetings via closed circuit television. After the rally the President is expected to return to Washington armed with what he will call "the support of the masses of people who want this program."

In addition, the Administration forces are organizing "coffee hours," sending spot announcements to radio stations, booking speakers on radio, distributing millions of pamphlets and sending out a steady stream of news releases.

All-Out Effort Needed from Physicians and Their Friends Now

A statement released April 16 by Dr. F. J. L. Blasingame, executive vice president of the AMA, stated that medicine "can win this battle." He said that he could not "stress too strongly that this is the hour for action." We can win and we will win if each physician, his wife, each branch, county medical society and auxiliary will do a minimum amount of work. Each physician is urged to:

- 1. Hold a TV "watch party" both on the evening of May 20 and May 21 to watch the President and the AMA's answering program. Invite your friends, neighbors and acquaintances, furnish them with stationery and obtain letters in opposition to King-Anderson.
- 2. Urge your patients to watch the AMA program on May 21 and to protest the King-Anderson bill.
- 3. Work with your branch and county medical society and auxiliary; arrange speaking engagements for the week following May 20 before as many lay groups as possible to correct false impressions and to generate the writing of letters to Congress.
- 4. Write letters to the editor of your local newspaper correcting misstatements of fact occurring on the Administration's TV program and give medicine's views on the King-Anderson bill.

Sample newspaper advertisements, news releases and suggestions for radio and TV programs are available from the AMA. The AMA on May 20 will wire suggested statements and suggestions for radio and TV programs which any county medical society schedules for May 21.

Need any help? Communicate with Mr. Walter L. Oblinger, Director of Legislative Activities or with Dr. F. J. L. Blasingame, AMA, 535 N. Dearborn, Chicago 10, Illinois.

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The ILLINOIS Medical Journal

Clinical Articles

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Adjunctive Treatment of the Chronic Alcoholic with

Hexacyclonate Sodium

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REASONS
WHY
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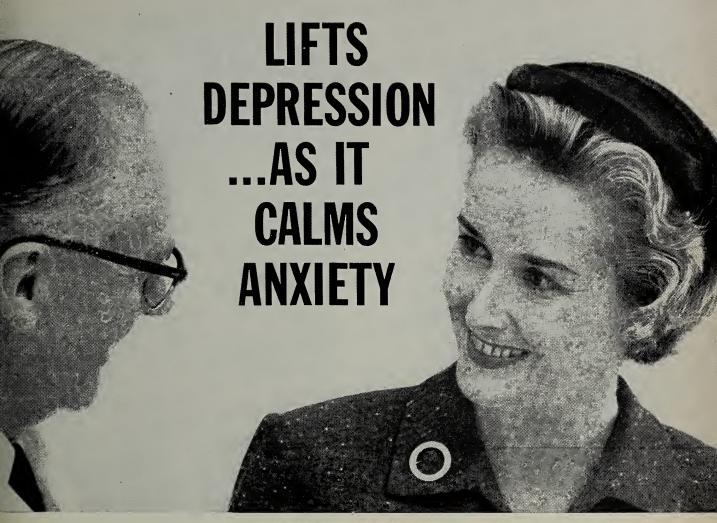






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"I feel like my old self again!" Thanks to your balanced Deprol therapy, her depression has lifted and her mood has brightened up - while her anxiety and tension have been calmed down. She sleeps better, eats better, and normal drive and interest have replaced her emotional fatigue.

Brightens up the mood, brings down tension

Deprol's balanced action avoids "seesaw" effects of energizers and amphetamines. While energizers and amphetamines may stimulate the patient - they often aggravate anxiety and tension.

And although amphetamine-barbiturate combinations may counteract excessive stimulation they often deepen depression and emotional fatigue.

These "seesaw" effects are avoided with Deprol. It lifts depression as it calms anxiety - a balanced action that brightens up the mood, brings down tension, and relieves insomnia, anorexia and emotional fatigue.

Acts rapidly - you see improvement in a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly - often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

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Dosage: Usual starting dose is 1 tablet a.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminaethyl benzilate hydrochloride (benactyzine HCI) and 400 mg. meprobamate. Supplied: Bottles of 50 light-pink, scared tablets. Write for literature and samples.



I SEE IT FROM '360'

By ROBERT L. RICHARDS Executive Administrator

The following article recently was sent to my office, unsigned. Its message is provocative and especially pertinent at Annual Meeting time.

The M.D.'s Responsibility to His State Meeting

At the turn of the century the annual state meeting was an occasion eagerly anticipated, where professional exchange of experience and avid attendance at lectures provided the best avenue for continued medical education. Medical movies were rarely available, TV wasn't even imagined, and even access to literature was generally confined.

Today, the busy practitioner is bombarded with literature, swamped with elaborate brochures, and interrupted in the care of patients by detail men. His hospital staff demands his presence at frequent meetings, and his specialty group or GP unit seeks his attendance at scientific meetings. Result: the physician is either a nomad from his practice, or he eliminates all meetings other than three or four each year.

In such a situation many state medical meetings are among the "also rans," providing little of the glamour or overwhelming program offerings of a national meeting. And yet, a state medical meeting has something of *special* value to the practitioner which is worth preserving. It is the finest "grass roots" medical meeting which can be developed, big enough to provide a stimulating program with out-of-state speakers and presentation of good scientific exhibits, yet small enough to provide renewed fellowship with former classmates and faculty members.

Why then, is the average state meeting suf-

fering a severe case of attendance malnutrition? In some instances poor program planning may be the answer. Often there is a lack of imagination in providing new modes of presentation. Panels, demonstrations, movies, TV, "wet clinics"... all are an important part of a modern-day medical convention, and the program committee which fails to utilize these teaching devices is issuing a blanket invitation to stay away from the meeting itself.

Even the technical exhibits at a well-run medical meeting have educational benefits to be considered. The educational aspects of the modern-day medical exhibit should not be overlooked or derided by the purist M.D. who scornfully brands all displays as "technical prostitution." He is possibly unaware of the fact that most of the scientific exhibits he admires and studies are largely supported by funds from the commercial houses. He accepts the lectures and demonstrations on the scientific program itself with little recognition that without exhibit support he would be asked to pay a registration fee of \$25 to \$50.

When attending your state meetings, it is important that your patients either read this legend on your office door: "To My Patients: I am Attending My State Medical Meeting so I Can Better Serve You. Please call Doctor ——in My Absence," or your office girl should be asked to explain your absence in a similar manner.

Your state meeting is worthy of your support . . . and it can only remain a vital factor in the life of your state if you attend and take an active role in all its aspects.



both victims of "communicable"* ANXIETY

both responsive to

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widely favored for children

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because of its efficacy, relative freedom from side effects...and its excellent flavor which makes administration a pleasure instead of a project

equally effective for grownups

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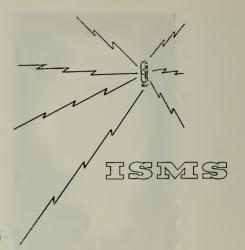
and equally well tolerated by patients of any age...no dulling of mental acuity to interfere with normal activities of busy adults

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Announcements

Disaster Medical Care Conference

The annual National Conference on Disaster Medical Care in Chicago, June 23, will have as its theme "Community Preparedness for Emergencies." Sponsored by the Council on National Security of the American Medical Association, the one-day meeting at the Palmer House immediately precedes the AMA's annual meeting.

The three program divisions are: means of achieving community preparedness, meeting the needs of the public and newer techniques to meet professional needs.

The keynote address, "Preparedness at the Community Level — an Urgent Goal," will be delivered by Dr. Luther L. Terry, Surgeon General of the U.S.

Additional information may be obtained from the Department of National Security, AMA, 535 N. Dearborn, Chicago 10.

Alumni Reunions

The University of Illinois Medical Alumni Association will have its annual seminar and reunion banquet Monday, May 14, during the annual meeting of the Illinois State Medical Society at Chicago's Sherman House. Dr. Morris Fishbein will be the main speaker at the banquet honoring the 50- and 25-year reunion classes. Gold and silver certificates will be awarded to each class respectively. The Alumnus of the Year also will be named, and the association's 1962-63 officers will be elected.

The association may be contacted at 1853 W. Polk St., Chicago 12, for more data.

The annual Faculty-Alumni Reunion of Northwestern University Medical School will take place Saturday, June 9, at the Lake Shore Club of Chicago. Husbands and wives of alumni are invited. Reservations at \$8 per person may be made at the Medical Alumni Office, 303 E. Chicago Ave., Chicago 11, until June 6.

The university is also holding an alumni luncheon Tuesday, June 26, at Abbott Hall on the Chicago campus during the AMA convention. Reservations at \$2.50 each may also be made at the Medical Alumni Office, or at the registration area of the AMA convention.

June 27 is the date of the golden anniversary alumni reunion dinner during the Chicago Medical School's Homecoming Week. The event, held during the annual meeting of the AMA, will be in the Guildhall in the Ambassador West Hotel.

Education Courses at County Hospital

The summer-fall courses offered by the teaching faculty of the attending staff at Cook County Hospital are as follows:

"Hematology," the week of June 4; "Surgical Technic," two weeks beginning June 4, July 23 and September 10; "Surgery of Colon and Rectum," the weeks of June 4 and September 17; "Neuromuscular Diseases," two weeks be(Continued on page 515)

Announcements (Continued from page 510)

ginning June 11; "Fractures and Traumatic Surgery," two weeks beginning June 11 and October 1; and "Gallbladder Surgery," three days beginning June 18 and October 8.

"Advanced Electrocardiography," the week of June 18; "Surgery of Hernia," three days beginning June 21 and October 11; "Vaginal Surgery," one week beginning June 25 and August 6; "Pain Relief in Childbirth," three days beginning July 11; "Proctoscopy and Sigmoidoscopy," the week of July 16; "Obstetrics, General and Surgical," two weeks beginning July 16; "General Surgery," the week of September 17; "General Practice Review," the week of October 8; "Advances in Medicine," the week of October 15; and "Blood Vessel Surgery," the week of October 22.

Address the registrar at 707 S. Wood St., Chicago 12, for complete details.

A course on "Electrical Techniques in Biology and Medicine" will be given at *Case Institute of Technology*, Cleveland, June 25 to July 6. It is designed for research personnel in the medical sciences and engineering and will concentrate on the nature of bodily activities that can be translated into measurable forms of electricity.

The origin of such activities, the instruments measuring them and the interpretation of electrical signals received will be main discussion subjects.

The institute can be contacted at University Circle, Cleveland 6.

PG Courses

The Chicago Heart Association has announced a postgraduate course on the basic physiology and psychology of work relating to cardio-vascular patients to be held June 18-22, at the Tudor Arms Hotel, Cleveland.

The course, a workshop limited to 150 participants, will include lectures, demonstrations, individual participations and testing, problems and group discussion. It is being conducted under the auspices of the American Heart Association, the Cleveland Area Heart Society, the Heart Disease Control Program of the U.S.

Public Health Service and Western Reserve University. Laboratory facilities of the university and affiliated hospitals will be used for field visits.

Those wishing to attend or to obtain further information may write Dr. Herman K. Hellerstein, Cleveland Area Heart Society, 1689 E. 115th St., Cleveland 6.

Occupational Medicine, a full-time, eight week course for physicians, will be presented September 17 through November 9 by the New York University Postgraduate Medical School. Its objective is to meet the need for specialized training in industrial medicine.

Formal instruction will be supplemented by field trips to industrial plants, governmental agencies concerned with industrial health and to union health centers.

The tuition will be \$375, with an additional \$25 for field expenses.

Write the office of the associate dean of the school, 500 First Ave., New York 16, for details.

Patients Sought for Glycogen Study

The cooperation of physicians is requested in obtaining patients with glycogen storage diseases for a current study at the Clinical Center, National Institutes of Health, Bethesda, Md. Especially needed are patients with deficient glucose-6-phosphatase. The diagnosis preferably should be established from enzymatic assays on liver biopsy tissue.

Various therapeutic measures will be evaluated, and hospitalization will be from one to three weeks.

Physicians wishing to refer their patients should write Dr. James B. Field, National Institute of Arthritis and Metabolic Diseases at the Institutes, Bethesda 14, or telephone 496-2715, area code 301.

Dr. Swenson to Discuss Pediatric Surgery

The Department of Pediatrics in cooperation with the Department of Surgery of the Stritch School of Medicine of Loyola University and Mercy Hospital will present Dr. Orvar Swenson in a luncheon talk Tuesday, May 22. Dr. Swenson, chief of surgery at Children's Memorial

Hospital, will speak on "What's New in Pediatric Surgery?" at 12:15 p.m. in the John B. Murphy Amphitheater at Mercy Hospital.

AMGA Annual Tournament

The forty-sixth annual Tournament of the American Medical Golf Association will be held at the St. Andrew's Country Club, West Chicago, Illinois, on Monday, June 25.

St. Andrew's has always been a mecca for golf tournaments affording the newest and finest of golf facilities with two championship 18 hole courses and a unique half-way house to provide rest and refreshment at the midway point of the game. PGA professional Bob Judson will be on hand to welcome AMGA members.

The following schedule of events for the tournament has been announced by C. Howard McDavitt, Jr., M.D., of Coral Gables, president of the AMGA:

8:00 a.m. through 2:00 p.m. TEE OFF 12:00 noon to 2:00 p.m. Luncheon

6:00 p.m. to 7:00 p.m. Cocktail Hour

7:00 p.m. to 8:00 p.m. Dinner

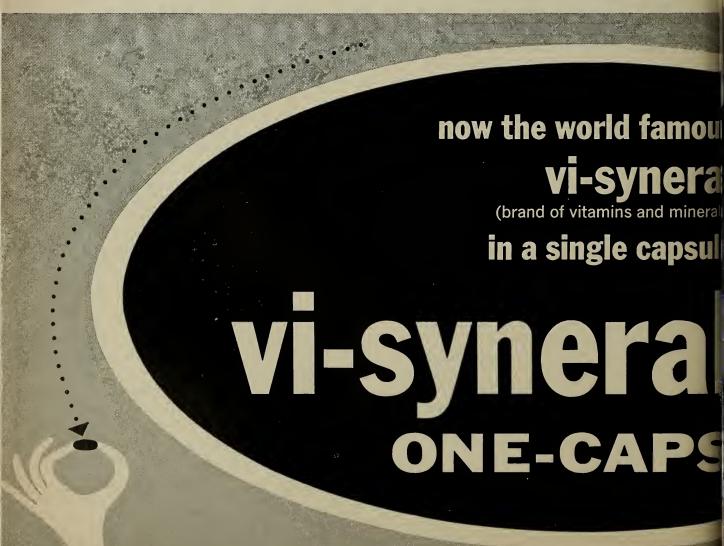
8:00 p.m.

Distribution of awards

Annual Meeting

The 1962 tournament fee of \$30 covers golfer's hat with AMGA emblem, locker and shower, luncheon, dinner and prizes. Complete tournament information will be sent to all members of the AMGA so that reservations may be made for participation in the 1962 tournament. The first 400 reservations will be accepted.

Physicians who are not members of the American Medical Golf Association are invited to apply for membership. A lifetime member-



ship is available to any AMA member with the payment of the \$3 membership fee. Thereafter, only tournament fees must be paid by participants. For further information please contact William G. McVay, executive secretary, P.O. Box 7007, Kansas City 13, Mo. Gene Arenson, M.D. is tournament chairman, AMGA, Illinois State Medical Society, Chicago.

Clinics for Crippled Children

- June 1 Chicago Heights (Cardiac), St. James Hospital
- June 6 Alton (Rheumatic Fever), Alton Memorial Hospital
- June 6 Carmi, Carmi Township Hospital
- June 6 Hinsdale, Hinsdale Sanitarium
- June 7 Effingham (General), St. Anthony Memorial Hospital
- June 8 Evanston, St. Francis Hospital
- June 12 East St. Louis, St. Mary's Hospital

- June 12 Peoria (General), Children's Hospital
- June 13 Champaign-Urbana, McKinley Hospital
- June 14 Springfield (General), St. John's Hospital
- June 19 Belleville, St. Elizabeth's Hospital
- June 20 Chicago Heights (General), St. James Hospital
- June 21 Bloomington (Cerebral Palsy—p.m.), St. Joseph's Hospital
- June 21 Elmhurst (Cardiac), Memorial Hospital of DuPage County
- June 21 Rockford, St. Anthony's Hospital
- June 26 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
- June 26 Peoria (General), Children's Hospital
- June 27 Aurora, Copley Memorial Hospital
- June 27 Springfield (Cerebral Palsy—p.m.), Memorial Hospital
- June 28 Bloomington (General—a.m.), St. Joseph's Hospital



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Various Childhood Tumors: Treatment with Actinomycin D and X-Ray Therapy

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ACTINOMYCIN D is an Antibiotic presently under investigation which can favorably affect the course of certain malignant tumors in man. The first of the actinomycins was named actinomycin A.^{1,2} The actinomycins isolated subsequently have also been given alphabetical designations — A, B, C, D, J, I, and X which differ structurally in amino acid composition.³ Like the other actinomycins, actinomycin D consists of a chromophor group and two polypeptide chains.⁴

Stock in 1950 first reported that the actinomycins had an inhibitory effect upon some experimental tumors in mice.^{5,6} Hackmann found that actinomycin C inhibited a number of animal tumors, particularly those of lymphatic origin.⁷ Suriura et al.⁶ and Farber et al.⁸ demonstrated similar effects of actinomycin on animal tumors.

Of particular interest was the report of Farber and co-workers published in 1955 in which they stated actinomycin D exerted a favorable effect on the course of Wilm's tumor and rhabdomyosarcoma in some cases.⁹ Tan, Dargeon and Burchenal, in a later report on the effect of actinomycin D in a large series of cases, described favorable effects in some cases of Wilm's tumor, rhabdomyosarcoma, neuroblastoma, bone sarcoma, sarcoma botryoides, Hodgkin's disease and lymphosarcoma.

The effectiveness of actinomycin D on tumors was later improved in many instances¹⁰ by combined treatment with irradiation. Tan and co-workers used irradiation in combination with actinomycin D because of the previous findings of Bases,¹¹ Farber, D'Angio and Maddock¹² which indicated that actinomycin D increased the severity of radiation dermatitis and shortened the time required for its appearance. These findings suggested that the combined antitumor effect of actinomycin D and x-ray would be greater in some instances than the effect obtained by either form of therapy used alone, as demonstrated by *in vitro* studies by one of the authors.¹³

During the past two years actinomycin D has been used in the treatment of certain tumors on the pediatric service of the Research and Educational Hospital. The cases selected for treatment were either children with tumors previously reported to respond favorably in some instances to actinomycin D therapy or

From the University of Illinois Research and Educational Hospitals, departments of radiology and pediatrics, Chicago, Illinois

children with tumors for which the response to actinomycin D had not yet been determined. The following describes the effects of actinomycin D in this group of 11 cases.

Method

Treatment with actinomycin D was given in the hospital in every case. Based on the recommended dose of 15 µg./kg./24 hours, each patient received actinomycin D intravenously in quantities varying from 0.2 to 0.4 mg. daily for 5 days. Most of the patients in our group received 2 courses of actinomycin D therapy. One patient received 3 and another 4 courses. The drug in most instances was injected into the side arm of an intravenous drip and allowed to enter the circulation over a 15-minute period. An attempt was made to treat with x-ray 4 hours after the administration of the drug but this was not feasible in all instances. Considerable variation in the form of radiation used resulted from the difference in tumors treated.

Discussion and Case Reports

Among the patients treated were 4 children with Wilm's tumor of the kidney. Actinomycin D has been employed by several groups in the treatment of Wilm's tumor after the removal of the primary tumor by surgery when metastatic lesions had become clinically evident. Instead of waiting for the appearance of metastases, we elected to treat with actinomycin D when possible at the time of the original surgery. We reasoned that malignant cells were already disseminated as shown by Long and co-workers, 14 and that these cells might be more easily destroyed by actinomycin D before relatively large, well-established metastases had formed. Therefore in each of 3 cases available to us for original therapy actinomycin D therapy was administered shortly after nephrectomy.

Case 1

A 3½-year-old Mexican girl was admitted for treatment one week after an abdominal mass on the left side was detected. An excretory urogram indicated the presence of a Wilm's tumor. A nephrectomy was performed, and tumor cells were isolated from the peripheral blood.

Twenty-four hours after surgery the first dose of actinomycin D was administered, and x-ray therapy was given the same day. A five day course of actinomycin D was given and resulted in nausea, anorexia and vomiting. Treatment with prochlorperazine (Compazine®) resulted in some improvement of the toxic symptoms. Four weeks later the child was given a second course of actinomycin D and developed severe leukopenia. The child received a total of 3600 r administered to the left renal bed. This patient is alive and free of any evidence of recurrence of the tumor 22 months after surgery.



FIGURE 1, Case 2. $2\frac{1}{2}$ -year-old male with stomatitis resulting from actinomycin D therapy.

Case 2

A 2½-year-old Mexican boy was admitted for treatment of an abdominal mass known to have been present for a period of 2 months. An excretory urogram performed shortly after admission indicated the presence of a Wilm's tumor on the left side. A nephrectomy was performed with removal of some adjacent nodes which appeared to be in-

vaded grossly by tumor. Blood samples taken during surgery revealed no tumor cells. Actinomycin D therapy was instituted 48 hours after surgery and followed with x-ray therapy. The x-ray therapy consisted of 2000 r given over an 80-day period. As a result of the actinomycin, the child developed nausea, vomiting, anorexia, fever, stomatitis and lethargy (Fig. 1). A severe degree of leukopenia and anemia occurred. This child also developed almost total alopecia, several months being required for regrowth of hair. Another toxic reaction was severe erythema in the area of roentgen therapy, followed by desquamation and sloughing of the superficial layers of the skin. It took several weeks for the skin to heal. A final toxic reaction was a thrombophlebitis in the vein used for actinomycin injection (Fig. 2). It is now 18



FIGURE 2, Case 2. Left arm antecubital region demonstrates reaction that can be produced when there is leakage of the drug into tissues during intravenous administration.

months since surgery, and the child is asymptomatic and free of any evidence of recurrence of the tumor.

Case 3

A 4½-year-old Caucasian girl was admitted to the hospital one week after detection of an abdominal mass. Abdominal pain had been present for a period of one month. An excretory urogram performed by the referring physician revealed the presence of a Wilm's tumor on the left side. A nephrectomy was performed, and tumor cells were isolated from the peripheral blood. Forty-eight hours after surgery actinomycin therapy was instituted and followed with x-ray therapy. A single course of actinomycin and a total of 1950 r in radiation were administered. This child developed anorexia, nausea, vomiting, and diarrhea following actinomycin D therapy. Severe anemia and leukopenia resulted which persisted for several weeks. This child also developed almost total alopecia which persisted for several months. Figure 3 demonstrates the alopecia, and Figure 4 shows regrowth of hair. She also developed erythema of the skin over the area irradiated with subsequent desquamation of the skin over this area. It took a period of six weeks for the skin to heal. She also developed a thrombophlebitis. Twenty-seven months postoperatively, this child is well with no sign of recurrence. The routine use of actinomycin D at the time of surgery for Wilm's tumor obviously can not be recommended on the basis of these





FIGURE 3, Case 3 (left). $4\frac{1}{2}$ -year-old female with alopecia occurring during the course of actinomycin D therapy.

FIGURE 4, Case 3 (right). Patient five months after her alopecia with complete restoration of hair growth.

three cases. The period of follow-up is still sufficiently short that metastases may still appear.

Discussion of Case 3

The recent report of Farber et al. 15 describes treatment of 8 children with Wilm's tumor for the period from 1956 to 1958 with surgery, xray and actinomycin D. One child with bilateral Wilm's tumor died six months following surgery. The remaining seven cases were well 32 to 38 months after surgery. At the Boston Children's Hospital the cure rate for Wilm's tumor has varied from 40 per cent to 48 per cent.15 The recent results suggest that actinomycin D used at the time of surgery in conjunction with x-ray may improve the results now obtained in the treatment of this tumor. Assuming a 50 per cent recovery rate for Wilm's tumor by standard treatment, the probability of obtaining by chance 10 out of 11 complete recoveries (as obtained by combining Farber's cases with ours) is quite small. However, since some cases of Wilm's tumor recover completely after surgery alone or after surgery and x-ray therapy, the good results obtained in our three successive cases may have been fortuitous. It is evident that the toxic effects of actinomycin D convert the usual smooth postoperative course into a period during which the patient suffers from severe hematologic, gastrointestinal and dermatologic reactions.

Nevertheless, these preliminary observations suggest that actinomycin D administered dur-



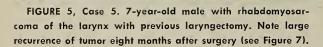




FIGURE 6, Case 5. One month after electron beam and actinomycin D therapy. Patient is well 11 months later.

ing the postoperative period may reduce the incidence of metastasis now found after surgical extirpation and x-ray therapy for Wilm's tumor. Of 5 cases of Wilm's tumor treated at the Research and Educational Hospital by surgery and x-ray over the 3-year period immediately prior to this study, 4 are dead of metastases and 1 is completely well. We therefore plan to continue to treat new cases of Wilm's tumor for the present with actinomycin D and x-ray in the postoperative period. While it would be preferable to alternate cases between those treated with actinomycin D in the postoperative period and those treated in the standard manner, the relatively small number of cases available to us for treatment makes this type of study unfeasible.

Case 4

A 3½-year-old girl developed pain in the right upper quadrant following an injury to the abdomen. Because of progressive abdominal enlargement over a one month period an exploratory laparotomy was performed at another hospital, and extensive metastases to the liver from a Wilm's tumor were found. On assignment to the Research and Educational Hospital for care, the patient was treated with two courses of actinomycin D and with x-ray (3800 r). Minimal improvement was obtained, but the patient deteriorated rapidly and died

three months after hospital admission.

Discussion of Case 4

This case illustrates that actinomycin D may have little effect in the treatment of Wilm's tumor after extensive metastases have developed. While the studies of Farber et al. and Tan et al. have shown a distinct palliative effect in 60 per cent of their cases and apparent complete regression in a few cases after metastases have occurred, 10,15,16 the use of actinomycin D for the treatment of metastatic Wilm's tumor would appear to be of limited value.

Case 5

A 7-year-old white male with a one year history of progressive stridor was admitted. A diagnosis of rhabdomyosarcoma of the larynx was made 10 months prior to admission. A laryngectomy was done, eight months after which an indurated mass appeared in the neck, and recurrence of the tumor was diagnosed. The patient was referred to the Research and Educational Hospital, where he was treated with the electron beam of the betatron and actinomycin D. He received electron beam therapy for 55 days with a total dose of 7850 electron beam units. A first course of actinomycin D was instituted one week after the start of betatron therapy. Toxicity in the form of



FIGURE 7, Case 6. Two-year-old female with complete obstruction of left kidney and partial obstruction of the right kidney from a recurrence of a pelvic mesonephroma operated one year previously (See Figure 9).

anorexia, nausea, lethargy and pallor were noted. Five weeks later a second course of actinomycin D was given, and nausea with vomiting occurred which was controlled with chlorpromazine. The tumor regressed with this therapy until no local mass was palpable. Figures 5 and 6 show the regression of the tumor under treatment. The child was last seen 21 months after betatron and actinomycin D therapy. At this time there was no sign of local or distant recurrence of the tumor.

Discussion of Case 5

Rhabdomyosarcoma of the larynx is a very rare tumor. In a 30-year period only one case was seen at the Mayo Clinic out of a total of 26 tumors of the larynx which were not carcinoma.¹⁷ In a 10-year study at Baylor in which 116 tumors of the larynx were seen there was no case of rhabdomyosarcoma.¹⁸ Dr. Hollinger states that this is the only case of rhabdomyosarcoma of the larynx which he has seen, although he has seen one rhabdomyosarcoma of the trachea.¹⁹ St. John considers this tumor one of the most malignant and radio-resistant of all sarcomas of soft tissue origin.²⁰ Farber et al. and Tan et al. have observed an increase



FIGURE 8, Case 6. Restoration of normal function bilaterally following actinomycin D and pelvic irradiation therapy.

in radiosensitivity of rhabdomyosarcoma when treated with actinomycin D.^{10,15} Anderson reports no known five-year survival prior to actinomycin D therapy, most patients expiring within one year.²¹ Our present case has survived 31 months after initial surgery and 21 months after betatron and actinomycin D therapy.

Case 6

A 2-year-old white female was admitted with a three-month history of vaginal bleeding. On admission an abdominal tumor was found, and during rectal examination a fragment of tissue was expelled from the vagina. This tissue was found to be a portion of a mesonephroma. A total hysterectomy, bilateral salpingectomy and a proximal vaginectomy were performed. Immediately postoperatively, no other therapy was given. The child did well until one year later, when recurrence of the tumor was noted. An exploratory celiotomy revealed local recurrence of the tumor with spread to the bowel. An excretory urogram (Fig. 7) demonstrated complete obstruction of the left kidney and partial obstruction of the right kidney. The patient was given a course of actinomycin D and x-ray therapy to the pelvis. A follow-up excretory urogram (Fig. 8) showed both kidneys functioning and the ureters of normal size. Radi-



FIGURE 9. Enhanced response of skin to x-rays by actinomycin D. Skin test on left thigh of child with Wilm's tumor. 700 r, 300 r, and 500 r were given left to right respectively. Uniform and exaggerated response in all fields.

ation therapy, consisting of 2400 r over a 2week period, was associated with a leukopenia. Two weeks later a second course of actinomycin D was given without x-ray, and no side effects were observed. Six months later, because of persistence of the tumor with secondary extension, a third course of actinomycin D was given with 3200 r of x-ray. Although this was followed by temporary clinical improvement, five months later there was further progression of the tumor and a fourth course of actinomycin D and x-ray (1500 r) was given. This treatment resulted in leukopenia, emesis, lethargy, diarrhea, severe radiation dermatitis, alopecia, fever, oliguria and azotemia, from which patient recovered. She was last seen in our clinic four months later with a larger abdominal tumor mass and edema of the extremities. She died subsequently in a community hospital from the effects of the tumor.

Discussion of Case 6

Mesonephroma is another rare tumor which occasionally occurs in childhood. The prognosis is very poor, and most patients expire one year after surgery.²² The response of this tumor to actinomycin D and x-ray therapy suggests that such combined therapy given in the immediate postoperative period might improve the prognosis.

Cases 7-11

Cases 7 and 8 were generalized Hodgkin's disease and generalized Ewing's sarcoma and showed only palliation for one year and six

months, respectively, after actinomycin D and x-ray. Cases 9 and 10 were an advanced neuro-blastoma and an advanced undifferentiated sarcoma showing no response to the drug and x-ray therapy. Although Tan,¹⁰ Shaw²³ and Pinkel²⁴ noted that some neuroblastomas responded to actinomycin D, the response was not so striking as that of Wilm's tumors. Case 11, an 8-month old white female infant with a rhabdomyoma of the heart, was recently treated with actinomycin D and electron beam of the betatron. She is well 12 months after treatment.

Discussion of Therapy

Despite its toxicity, actinomycin D is an effective antitumor agent for certain childhood neoplasms and deserves further investigation. When first using the drug, the radiotherapist may experience some disappointment, indifference or surprise over the skin changes that occur in his patients. Marked enhancement of the treated skin field does not occur in all cases; although actinomycin D is a toxic drug, the dosage has to be sufficient to produce this reaction. It also may be important that a definite time interval between administration of the drug and the subsequent irradiation be observed.25 Skin changes are more readily produced if first the antibiotic is given intravenously two to four hours preceding the irradiation. Figure 9 is of a skin test from the thigh of a child with a Wilm's tumor and whose abdomen received the drug and irradiation. It shows the severe reaction of all portals to the level of vesiculation and early desquamation. The portals received 700 r, 300 r, and 500 r left to right respectively, so that this result could not have been obtained with irradiation alone.

During the combined therapy, no adhesive dressing should be used since marked desquamation will occur when the bandages are removed. At present, there is nothing to indicate that total radiation dosages should be lowered. At times the dose rate of radiation may have to be reduced temporarily during cpisodes of skin reactions or of mild neutropenia if large fields are used. All of the skin reactions and the other complications of toxicity have been reversible in our experience, with no evidence of late sequelae. Those interested in radiation

therapy, the skin and the use of actinomycin D may find more details in another report by one of the authors.26

Of the 11 patients in this study, nine received 240 K.V. H.V.L. 2.2 mm. Cu as the chief quality of radiation used, while the two remaining patients (one with rhabdomyosarcoma of the larynx and the other with rhabdomyoma of the heart) received electron beam therapy 21 mev betatron.

It is possible that further alterations in the basic chemical structure of actinomycin D will produce a more effective and less toxic compound. Tan and co-workers recently have reported on the use of actinomycin F₁ which differs structurally from actinomycin D by the presence of alloisoleucine instead of proline.²⁷ This drug does not appear to differ appreciably in antitumor effect or toxicity from actinomycin

On the basis of the favorable results already obtained, a more aggressive attitude toward the treatment of malignant disease in childhood utilizing newer antibiotic and chemotherapeutic agents in association with radiotherapy is warranted. Until such time as definitive effective therapy is established for each tumor it would appear that more rapid progress may be obtained by controlled studies carried on at special institutions.

Summary

Eleven cases of neoplasms occurring in children have been treated with actinomycin D and x-ray with variable results. Three Wilm's tumors and a rhabdomyosarcoma of the larynx have shown excellent results—alive 10, 14, 17, and 11 months, respectively. Temporary improvement was evident in the Ewing's sarcoma, Hodgkin's sarcoma, undifferentiated sarcoma and mesonephroma of the vagina. Minimal or no response was noted with neuroblastoma and Wilm's tumor with metastases. Recently a rhabdomvoma of the heart was treated.

Toxic effects were fever, anorexia, nausea, vomiting, alopecia, severe dermatitis, stomatitis, thrombophlebitis, leukopenia and anemia.

The average dose of actinomycin D was 0.2 mg. for five days, calculated on the basis of 15 μg./kg./24 hours and administered through the side arm of an intravenous drip over a

10-15 minute period. X-ray was given 3-4 hrs. thereafter to obtain a maximum potentiating effect.

There is evidence suggesting that early introduction of this combined therapy before evidence of clinical metastases will improve the prognosis of Wilm's tumor in childhood.

Acknowledgement

Gratitude is expressed to Dr. Heyworth N. Sanford, Chief of Pediatrics at the Research and Educational Hospital, for his support during clinical trials of this new drug and his help in preparation of the manuscript.

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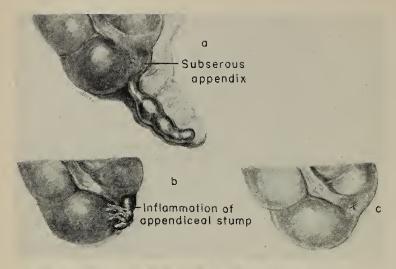


FIGURE 1. a — Probable appearance of cecal region at initial surgery. b — Recurrent appendicitis in residual stump. c — Cecum after appendectomy.

Acute Appendicitis in a Residual Appendiceal Stump

WILLIAM J. GILLESBY, M.D., F.A.C.S., Chicago

ALTHOUGH THE PROBLEM of acute appendicitis would seem to be solved, there have been several recent reports of appendiceal stumps with appendicitis. ¹⁻⁴ The literature contains reports of cases in France, Denmark and Germany. ⁵⁻⁹ It is apparent that the problem is not unique in America and although not common, deserves attention.

Each of these reports specifies the length of the stump — from 1 to 3 cm. Descriptions are difficult to assess but the residual stump was proximal to ligation in most cases. The appendix distal to ligation apparently atrophied and was absorbed.

Siegel reported a stump abscess forming 23 years after appendectomy; the stump was ½ inch long. Corcos⁶ reported a similar occur-

rence after a much shorter postoperative interim. Roth⁹ reported a case of an appendiceal stump with right adnexitis discovered seven years after appendectomy for a ruptured appendix. He believed the adnexitis was closely related to the appendicitis in the retained stump.

The probability that inadequate exposure was responsible for the error in technique seems logical from analyzing these and other reports.^{11,12} Sigel and Wolcott reported two cases in which appendectomy had been performed during right inguinal herniorrhaphies 8 and 35 years previously. Perruchio et al.⁸ report a similar case. Appendectomy performed as a prophylactic measure during surgery for unrelated disease was a common finding in these cases. Rex et al.¹⁰ reported 14 cases with cecal inflammation and scarring. It seems possible that some of these cases represent incomplete appendectomies.

This case report is representative of 11 cases

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of acute appendicitis occurring from three months to 12 years following appendectomy. All of these cases have been seen in the past 15 years and are so similar that the one reviewed here essentially describes the others.

Case report

A Negro man age 37 was admitted to the Hines VA Hospital in 1953 with abdominal pain. Temperature 99.6 F., pulse 110 and white count 17,000 with a marked shift to the left. Pressure over the left lower quadrant produced pain in the right lower quadrant. Rebound tenderness was moderate. His history revealed that 10 years previously he had suffered an acute abdominal pain, for which appendectomy was performed. Recovery was stormy and he continued to have pain in the right lower quadrant for some weeks. He had been given acetylsalicylic acid and mild sedatives and was told that everything would be all right. For the next four years he experienced pain intermittently about every three to six months, for which a diagnosis of psychoneurosis was made on two occasions. Pain in the right lower quadrant continued intermittently to the time of his admission to Hines VA Hospital in 1953. Because his pain continued a tentative diagnosis of residual appendicitis was made and exploratory surgery undertaken.

Under general anesthesia a right lower paramedian incision was made and the abdomen opened. There was a little fluid in the right lower quadrant which was shown to be clear and sterile. The site of the appendix at the confluence of the taeniae coli was occupied by an indurated mass 3 cm. long, about the diameter of a man's index finger and covered with serosa (Fig. 1b). This mass was freed rather easily from the wall of the cecum without any unusual bleeding and was found to be the stump of an unremoved subserosal portion of an appendix. Appendectomy was then performed and the stump, after tight ligation, was inverted with the purse string (Fig. 1c). Recovery was uneventful. The patient has been seen several times postoperatively and his abdominal pains have been completely relieved; he has continued to work without further complaint.

Microscopic sections of the removed ap-

pendix showed acute appendicitis with obstruction due to fecalith. It is probable that the appendicitis at the first operation appeared with a portion of the appendix being covered by a membrane due to inflammation (Fig. 1a) and that the surgeon removed the dependent portion of the appendix without dissecting the appendix away from the wall of the cecum.

Discussion

The history of previous appendectomy is to be viewed with skepticism if recurrent symptoms suggest acute appendicitis. Appendectomy must be complete and dissection should be carried down to the confluence of the three taeniae coli of the cecum.

Each of us has his own idea as to the proper method of performing an appendectomy. My own feeling is that tight ligation and purse string close to the base is important, the tight ligation being performed so that there will be some slough intraluminally.

Summary

- 1. A case history representing 11 cases of appendicitis following appendectomy is pre-
- 2. Inadequate appendectomy accounts for this surgical error.
- 3. The probable explanation for this is inadequate exposure and disregard of the normal anatomical landmarks.

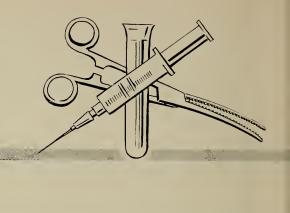
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COOK COUNTY HOSPITAL

Carotid Sinus Hypersensitivity

Moderator:

ROBERT J. FREEARK, M.D.

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Discussants:

ROLF GUNNAR, M.D.

Assistant Professor of Medicine, University of Illinois College of Medicine; Attending Physician and Director of the University of Illinois Medical Services at Cook County Hospital

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DR. ROBERT FREEARK: Although syncope or fainting is an uncommon symptom of patients on a general surgical ward, it is one of the most frequent symptoms confronting the general practitioner and internist. Its causes include a wide variety of local and systemic disorders, presenting an unusual opportunity for differential diagnosis.

Recent progress in vascular surgery has rekindled the interest of surgeons in the patient who experiences a sudden loss of consciousness. In previous conferences we have emphasized the picture of the "little stroke" or transient period of unconsciousness that often accompanies occlusive disease of the carotid arteries. The excellent results of surgical correction of this arteriosclerotic narrowing of neck vessels is one of the brightest chapters in modern vascular surgery. In our eagerness to identify and treat surgically patients with syncope resulting from carotid vascular insufficiency, we must be constantly mindful of the other causes of this symptom. The case to be discussed here emphasizes this easily forgotten point. While the patient is suffering from a relatively uncommon cause of fainting, the ease and frequency with which it is overlooked makes it an appropriate topic for our surgical conference.

We have enlisted the aid of Dr. Rolf Gunnar, a recent addition to the full time staff at Cook County Hospital. In his major area of interest, cardiology, he has proven an able investigator, an astute diagnostician and stimulating teacher. Recently he was appointed director of the teaching program in Medicine for the University of Illinois at Cook County Hospital.

We will begin with the case presentation by Dr. Banich.

Dr. Francis Banich: The patient is a 58-year-old white male who presented himself to Cook County Hospital in September 1960 with a history of episodes of numbness and weakness in his left arm accompanied by lightheadedness and blurred vision with occasional loss of consciousness. History revealed only appendectomy, ventral herniorraphy and bilateral fenestration procedures for otosclerosis.

Physical examination revealed a well-nourished male with BP 130/70, pulse 72, and no evidence of systemic illness or neurologic de-

ficit. All pulses were intact including the superficial temporals, and no bruits were heard in the neck. Digital pressure over the right carotid bifurcation produced a syncopal attack with accompanying mild left-sided Jacksonian type convulsion, while pressure over the left carotid produced no symptoms. Simultaneous recording of EKG, while stimulating the right carotid sinus, revealed five seconds of asystole. Atropine 1 mg. administered intravenously before stimulation caused a change in tracing to that of severe bradycardia of 30 beats/minute. However, the subjective symptoms of blurred vision and weakness in left arm persisted. Carotid angiography demonstrated a normal extra-andintra-cranial arterial system. Surgery was performed on September 23, 1960, after which the patient was entirely asymptomatic.

In January 1961 he was readmitted because of substernal aching pain which occurred with exertion. This was relieved by rest and subsequently responded to sublingual nitroglycerine. Complete GI and cardiac workup was within normal limits. The patient frequently complained of anginal pain but always admitted that it responded to medication.

On January 5, 1962, he presented with severe pretibial edema, bilateral basilar crepitant rales, and venous distention. Pulse was 120/min., weight 177 pounds, and there was subjective complaints of exertional dyspnea and orthopnea. He did mention that he had two syncopal episodes, the first while crossing a street and the second while in his room. Digitalization and diuretic therapy were immediately instituted. By January 12 his weight was 166 pounds and he felt very well but had another attack of syncope and blurred vision. On examination, right carotid massage was unremarkable, but left carotid sinus massage caused cardiac asystole, transient unconsciousness, and right sided tremor. Catheterization studies showed a fall in arterial pressure to zero on massage. Left carotid sinus surgery was performed on January 19, 1962.

Dr. Freeark: The anatomical area under discussion deserves a brief review. At the level of the hyoid bone within the wall of the internal carotid artery, near the bifurcation of the common carotid, there is located a highly complicated series of sensory nerve endings which act in response to changes in carotid

arterial blood pressure. This pressoreceptor is the carotid sinus that sends afferent fibers to the vagus nerve. When the blood pressure is elevated, a resultant lowering of the blood pressure and slowing of the heart is effected through stimulation of the vagus. These same physiologic responses in the heart rate and blood pressure may occur in susceptible individuals merely as a result of mechanical stimulation of these nerve endings during twisting of the neck, manual palpation, or in the course of surgery in this area. This patient appears to have an unusually sensitive carotid sinus.

Dr. Gunnar, are you certain this is his only problem and what other condition might be a factor in his transient episodes of neurologic deficit?

Dr. Rolf Gunnar: I think we should confine ourselves in this conference to the type of syncope which is of major interest to the surgeon. Therefore we will skip the most common cause of syncope, that is the so-called psychic syncope or the nervous individual who faints. The cardiac causes of syncope are becoming increasingly important because there are surgical corrections for some of these lesions. The arrhythmias which cause syncope and which the surgeon may be able to help are:

a. complete heart block or Adams-Stokes syndrome, caused either by cardiac asystole or ventricular fibrillation. It occurs in patients with complete heart block, usually the result of coronary artery disease. It may be difficult to diagnose this condition when inactive, and to know whether the patient merely is fainting or experiencing ventricular fibrillation. Once detected and confirmed, treatment is the same. If you can drive the heart at an adequate rate, the patients will not develop syncope. Medical treatment with ephedrine-like drugs may be tried but frequently is not adequate. Many of those patients succumb early in the course of their disease if it arises as a consequence of an acute myocardial infarct. However, if time permits, the treatment is to connect the patient to an external cardiac pacemaker and keep the heart going with electrical stimuli during the episode of fainting until one is prepared to put in an internal pacemaker. These tiny self-contained units generate their own electrical impulses and may be buried within the body wall

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on a near-permanent basis. This has been done several times successfully here at Cook County.

b. Certain outflow tract obstructions cause syncope and can be treated surgically. These include pulmonic or aortic stenosis. Pulmonic stenosis is usually congenital, while aortic stenosis may be either congenital or acquired, with fainting occurring at the end of the course of the disease. This now becomes an urgent problem. If a patient faints because of aortic stenosis or pulmonic stenosis, sudden death occurs within the next few months unless surgical treatment is instituted.

The nine other cardiac causes I will not go into but they include cor pulmonale and arrhythmias not associated with Adams-Stokes disease, such as paroxysmal atrial fibrillation. One that may be of interest is the type now described as flyer's syncope. It was first encountered in a pilot who was flying a jet aircraft during the war. He had something wrong with his oxygen mask so he went to blow it out and fainted. He landed his aircraft and it was found that when he produced a Valsalva maneuver, as in inflating a balloon, he also produced a cardiac asystole and would faint.

The anoxic syncopes we do not have to go into in great detail. This usually refers to persons with severe pulmonary disease over a long period of time who faint simply from lack of oxygen. Persons with orthostatic hypotension are not of importance to the surgeon unless he has created it by operation upon the sympathetic nervous system.

Carotid sinus syncope can be divided into three types: The first is the vasodepressor type. The carotid is a pressoreceptor and if you stimulate it, it causes a decrease in the sympathetic tonus of the peripheral vessels. As a result the blood pressure drops and the patient faints. This is a true stretch receptor. If you encase the carotid sinus so that it cannot distend and then increase the pressure inside the sinus, nothing happens. It is only if you expand the sinus that the response is observed.

Second is the cardiac inhibition response. This is the type under discussion today where pressure on the sinus causes the heart to stop or slow down markedly and numerous things can happen, such as severe sinus bradycardia, complete sinus arrest, arrhythmias such as ventricular fibrillation, sinus arrest or severe

bradycardia. With a patient who faints, there is usually a long period of asystole. It correlates somewhat with the degree of arteriosclerosis, and there is some thought that maybe patients who have a really prolonged faint after stimulation later will develop cerebral arteriosclerotic disease.

One should start examination with the patient lying down because it can be quite a frightening experience. The right carotid sinus should be massaged gently for about five seconds. You can try again for longer periods if you get no response; but if you get asystole, stop. If nothing happens massage the other side. Then if you want to reproduce the episode, you can do it sitting up. If a person has prolonged asystole and develops ventricular fibrillation lying down, you will not want to do it sitting up.

Certain things are known to enhance the irritability of this sinus. Among them are nicotine, digitalis, some infections such as acute rheumatic fever, and jaundice. The treatment for this type generally is to place the patient on large doses of atropine. This will in many cases relieve the symptoms and is important in rendering the patient safe for surgery. The original description by Weiss and Barker suggested that in over half of their cases there was pathology within the carotid bifurcation, such as aneurysmal dilatation or tumor which was adjacent to the carotid sinus.

The third is the cerebral type. This really has nothing to do with the carotid sinus and probably does not belong here. Weiss described pressure on the sinus causing fainting and convulsions. This is more likely a manifestation of the little stroke syndrome which Dr. Freeark mentioned earlier and represents either carotid or vertebral artery insufficiency. If you press firmly on the bifurcation, you cut off the blood supply to the calvarium and the patient faints. I think these patients should be taken out of the carotid sinus syndrome classification. That is why it was important that they visualized the cerebral vessels by angiography in this case before they went ahead and did surgery.

As far as surgery is concerned, if you denervate the carotid sinus and get rid of the episodes, you do so with the additional effect of increase in blood pressure for a period of time. You may find bradycardia for a while, and

some patients have developed atrial arrhythmia after having the sinus denervated. These return to normal after a few months.

DR. FREEARK: Ivan Zahony, our associate director of anesthesiology, administered a general anesthetic to our patient. He has had previous experience with the problem. To control the bradycardia during surgery he used upwards of 6 mg. of atropine, which is a very large dose. He and Dr. Collins have collected a series of these hypersensitive carotid sinus cases which were encountered during the course of neck surgery for cancer or some other disease, and they feel that about 10 per cent of patients have exaggerated irritability of the carotid sinus.

DR. GUNNAR: It is quite true that a high percentage of these cases have an irritable carotid sinus, especially in the group over forty. Levine's report is higher than 10 per cent. He thinks it is closer to 25 per cent.

DR. FREEARK: I am not clear on one point. What is the difficulty in diagnosing syncope on the basis of complete heart block or Adams-Stokes syndrome? Don't all patients with Adams-Stokes syndrome have persistent brady-cardia under 40/min. or is the rate subject to change?

DR. Gunnar: You should divide the syndrome further into those who develop transient heart block (during which period there may be a long episode of asystole) and the ones we are most familiar with, namely, those who have persistent bradycardia all the time. They may be able to function with a heart rate of 42, but if they drop to 36 or if they go into asystole they will faint. If the heart rate decreases they may even develop ventricular fibrillation.

DR. FREEARK: Dr. Gunnar, have you seen many cases of carotid sinus hypersensitivity? Is it a common disorder? I can not recall a previous case on the surgical services.

DR. GUNNAR: I have not seen a great deal of clinically symptomatic sinus sensitivity. I do not think it is seen as much as before because there are fewer persons who wear tight collars which press upon the sinus area.

DR. F. Banich: I believe there is some disagreement as to whether or not the cerebral form is exclusively a manifestation of cerebral vascular insufficiency. Many authorities feel that intracranial vascular insufficiency may play

a role but that the *transient* cerebral symptoms occur even when you do not occlude the carotid during massage. Some patients without evidence of carotid arterial disease may obtain unusual responses to sinus stimulation.

Dr. Freeark: Doesn't the "pure" cerebral type occur in the absence of any change in blood pressure or pulse rate?

Dr. Banich: The biggest series I was able to review was reported from London and included severe forms of carotid sinus disease but never in a pure form. They have always seen combinations of all three types.

Dr. Gunnar: The original classification is the one Weiss described. He said that in the cerebral form there is no dropping of pressure or slowing of pulse. This is now considered purely intracranial arteriosclerosis. In any patient with cerebrovascular insufficiency, symptoms develop if output is decreased even if you do not occlude the vessel completely but just decrease the flow by narrowing the vessel, slowing the heart, or lowering blood pressure.

Dr. Banich: One reason this man was considered for surgery was the persistence of cerebral symptoms even after partial control of the bradycardia with medication.

Dr. Gunnar: I suspect that you cannot get at his basic disease which is really cerebral insufficiency inside the skull. If you can prevent him from getting bradycardia and hypotension, this cerebral ischemia may never progress to the point of clinical symptoms.

DR. FREEARK: We will now show you the movie of this patient before, during, and after the second operation for denervation of his left carotid sinus. Dr. Banich will comment as it is being shown. (Movie shown here.)

Dr. Banich: Preoperatively, we can demonstrate the patient's problem. You see the patient and we are massaging the left side, which is the symptomatic side. This is just to show the objective manifestation of falling blood pressure and asystole. He experienced blurred vision, extreme dizziness, and tends to faint. This is the right side which we denervated several years ago. Massage and even complete occlusion failed to elicit any symptoms.

DR. FREEARK: This man's response to massage was even more profound than is depicted here. He clearly is greatly disturbed during these transient episodes.

Dr. Banich: This is a simultaneous recording of an electroencephalograph and electrocardiograph during the period of massage. Initially, he has a normal sinus rhythm and this persists with massage of the right side. Now we started stimulating the left carotid bifurcation by massage and you can see he goes into bradycardia, convulsions, and the heart actually stops. The electroencephalograph at that time shows hypoxic spikes in the brain wave pattern.

Now we will show the surgery. This is a simple dissection for exposure of the carotid bifurcation. The skin along the anterior border of the sternocleidomastoid muscle is incised and dissection was carried down through the cervical fascia and muscle retracted laterally to expose the carotid bifurcation. We tried to get along without Procaine injections into the sinus region until the anesthetist asked us to inject some. We were running continuous electrocardiographic tracing as a monitor. There was some change in the rate when the tape is being passed around the common carotid artery. Now the sinus itself is being infiltrated with Procaine.

DR. ROBERT BAKER: Did that cause a change in the electrocardiograph?

DR. BANICH: No, not with the injection. It stopped the little bouts of bradycardia, however. After isolating the common carotid artery, tapes were used to encircle both the internal and external branches. After infiltration of the adventitia of the vessel with Procaine all the adventitia and nerve fibers entering the area are "peeled" away from the deeper coats by sharp dissection until you see the avascular layer of muscularis. It comes off like onion peel. The dissection is now in the notch between the internal and external arteries. If you go too deep here you invite vigorous hemorrhage. The sinus is now completely denervated and the specimen has been removed. The bifurcation is now clean of adventitia and nerve fibers from one inch on both sides of the bifurcation. The sinus receptor may remain in the wall of the vessel but all of the nervous connections have been severed.

DR. FREEARK: The ease with which this procedure can be carried out makes me wonder about the role of medical or drug management for such a case. This may be a life-endangering syndrome, should one of these attacks occur

while the patient is crossing the street or driving a car. I would feel if the diagnosis is wellestablished and unless drug therapy is completely satisfactory, surgery is the preferable treatment. It can be accomplished under local anesthesia through a very limited incision. It is usually carried out rapidly and without difficulty. Dr. Banich alluded to the one technical detail in this operation: the decision as to how deep you want to go. This is not always easy to ascertain. At the time of the first operation, we were trying to get down to the nice "white" vessel wall as recommended by several authors. After Dr. Banich demonstrated what he thought was a thoroughly stripped vessel, I was not impressed and felt there was another layer to be removed. That other layer was fluid and we had to repair a small hole in a critical artery. However, it is a simple dissection. When you get into this plane between adventitia and media, and if you are not certain, send a tissue section to the laboratory for frozen section and find out if there is muscle tissue included. Adventitia is without muscle fibers and if you have muscle, you are too deep.

Dr. Gunnar, I think the occurrence of symptoms on the opposite side after having denervated one side nearly two years before is most unusual. It is interesting that the left side was not "sensitive" when tested prior to the first operation. Does bilateral involvement occur frequently enough to consider bilateral denervation in one stage?

Dr. Gunnar: I would object to bilateral surgery because of the importance of these pressoreceptors in compensating for changes in blood pressure and position. If you remove just one carotid sinus there will be orthostatic hypotension because the other side remains. There are other homeostatic mechanisms that can take over after a period of years, but I would be afraid to do both at once even if they were both hypersensitive.

DR. BANICH: Postural hypotension may be a serious problem. In the London series that I mentioned only two cases were bilateral and one had severe postural hypotension on testing but it did not present a clinical problem. This patient was asymptomatic but the readings showed tremendous drop in blood pressure on standing. Another complication is the constantly mounting, uncontrollable hypertension after bi-

lateral denervation. The only pressor receptor that is working is in the aortic arch and it may prove inadequate.

We will continue to follow this patient, who has done well and remained asymptomatic. He does not have postural hypotension. His blood pressure is 140/80 mm. Hg supine with no change in the standing position.

DR. FREEARK: We are indebted to our discussants for an interesting and enlightening discussion of an uncommon clinical problem. The increased awareness such a case creates in our house staff will undoubtedly provide further instances of carotid sinus hypersensitivity in near epidemic proportions. I sincerely hope so.

Summary and Conclusions

- 1. The sensory endings in the carotid sinus are basically stretch receptors which normally react to a rise in blood pressure. These stimuli are carried from the sinus to the ganglion nodosum of the vagus nerve and cause:
 - a. Bradycardia
 - b. Widespread vasodilation and fall in blood pressure
 - c. Diminished secretion of epinephrine
 - d. Depression or arrest of respiration
 - e. Diminished tone of skeletal muscle
 - f. Visceral changes, such as increased stomach tone and decreased bladder tone.
- 2. The carotid sinus is different from the carotid body which is located nearby but is a chemoreceptor and is affected by alterations in CO₂ and O₂ tension and by H⁺ ion concentration of the blood.
- 3. The clinical manifestations of carotid sinus hypersensitivity are classically divided into three groups which may be present singly or in combination.
 - a. Cardiac type with cardiac irregularities varying from bradycardia to asystole.
 This form will sometimes respond to atropine.

- Depressor type marked fall in blood pressure which usually responds to sympathomimetic drugs such as ephedrine.
- c. Cerebral type subjective symptoms of lightheadedness, vertigo, blurred vision, transient hemiparesis, mental changes (e.g., compulsive laughter), sensory changes in an extremity, or complete syncope with rare tonic clonic convulsions during unconscious interval no satisfactory medical treatment.
- 4. In examining for carotid sinus sensitivity, the examiner should massage only one sinus at a time with the patient in lying or sitting position. The normal response is a fall in systolic blood pressure of 10 mm. Hg and slight bradycardia. If, however, sinus pressure causes the symptoms of which the patient complains the diagnosis is established.
- 5. Additional facts:
 - a. Right sided disease is more common than left
 - b. Age of patient usually is 40+
 - c. Mild hypertension usually is present
 - d. Any movement about the neck can cause attack—tying tie, tight collar, turning head, etc.
 - e. True vertigo with nausea or tinnitus never is encountered
 - f. Cardia asystole must be greater than 3 seconds.
- 6. The evaluation of the patient must include a careful neurological examination plus carotid angiograms.
- 7. Severe forms of this syndrome must be treated by a surgical technique which is essentially the stripping of the adventitia or outer layer of the common, internal and external carotid arteries for a distance of 3 cm. above and below the carotid bifurcation, after having first injected this area with 0.5% Procaine.

Adjunctive Treatment of the Chronic Alcoholic with Hexacyclonate Sodium

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In Previous Years, the alcoholic patient was treated with such sedatives as barbiturates, bromides or paregoric. With the introduction of tranquilizers, the phenothiazines, reserpine, meprobamate, and similar drugs were also used. Quite recently a group of new drugs, known as psychic energizers or monoamine oxidase inhibitors were also introduced, but were found more useful in patients who were severely depressed than in those who were apathetic, chronically ill, and aged.

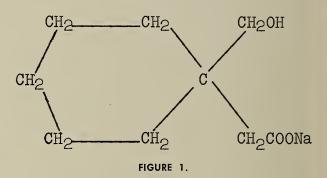
Since tension states are prominent and probably the basic causal factor in the behavior of the alcoholic,² the clinician has felt the need of and has long sought an ideal drug which, while alleviating tension, has maximum and consistent effectiveness with minimal risk of addiction, overdose, intoxication, or other side effects. Thus, it was decided to use the new central nervous system stimulant hexacyclonate in this double-blind study.

Chemistry and Pharmacology

Hexacyclonate is a white, crystalline compound freely soluble in water and alcohol, but practically insoluble in ether. A 5 per cent aqueous solution of the compound has a pH of 7.34. Chemically, it is sodium 3,3-pentamethylene-4-hydroxybutyrate; its structural formula is shown in Figure 1.

Pharmacologically, hexacyclonate exerts a stimulating action on the central nervous system similar to that exerted by pentylenetetrazole. However, it produces a much more potent effect. Experimental studies indicate that hexa-

From the Oak Forest Hospital of Cook County



cyclonate acts mainly on the brain, including the medullary centers, and that it also appears to affect the neuromuscular junctions.

Its analeptic effect was tested against various CNS depressants and in comparison with other CNS stimulants. In these tests hexacyclonate antagonized pentobarbital and tribromoethanol sedation in rats and mice, but did not antagonize the sedation produced by either chlorpromazine or reserpine. It produced effective respiratory stimulation when the respiratory center was depressed by barbiturates, chloralose, urethane and morphine. In normally anesthetized dogs, hexacyclonate had practically no effect on blood pressure, and appears to be rapidly metabolized by the body. Toxicity studies definitely indicate that it has a wide margin of safety and practically no cardiovascular effects.

Method

This study was conducted with ambulatory patients who were not considered in need of

specialized psychiatric treatment, but all were of the type that the average outpatient clinic would see and treat.

Twenty-one chronic alcoholic patients ranging in age from 41 to 75 years, average 56 years, were studied. Neuropsychiatric and psychologic examination of these patients prior to the experiment showed symptoms of pronounced phases of psychomotor agitation, anxiety, irritability, nervousness, apprehension, sleeplessness, some coloring of paranoid traits, false sense of well-being, and other symptoms. Of this group, 19 were males and two females. They were all ambulatory. The subjects were divided into two groups; an experimental group (11) ranging in age from 41 to 63, average 52 years and a placebo group (10) ranging in age from 51 to 75, average 64 years, as a control group. In the course of the experiment psychotherapy for both groups was also administered weekly.

Criteria of Evaluation

Three criteria were used in evaluating the results of treatment with hexacyclonate and psychotherapy or placebo and psychotherapy.

- 1. The extent of relief from presenting symptoms.
- 2. The degree and amount of stimulation affecting the central nervous system with special regard to mental response and speed of reasoning.
- 3. The degree of improvement in social and work adjustment.

Thus, the purpose of this study was to consider the effectiveness of the drug by whatever reaction the patient would show in mental and emotional behavior and also in his performance in the community, i.e., whether or not he could hold a job and interact with his fellows.

The following definitions were utilized in assigning final rating:

Marked—substantial to complete relief and improvement in mental-emotional symptoms with good social and work adjustment.

Moderate—considerable relief of mentalemotional symptoms, with significant improvement in social and work adjustment.

Minimal—some relief of symptoms but no improvement in social or work adjustment.

None—or no response to treatment.

Measurements

Standard psychologic tests for the measurement of mental efficiency, and the degree of emotional-social reactions were used:

The SRA Non-Verbal Aptitude Test—Form AH by R. N. McMurray and J. E. King, was used as an index of measure for general intelligence—sometimes called the aptitude to learn, to solve problems, to foresee and plan, to use initiative, and to think quickly and creatively.

The Personal Audit — Form LL by Clifford R. Adams and William M. Leepley was used as an objective test and as an index of personality traits. This test consists of nine parts. Each part measures a relatively independent component of personality; extreme results represent high percentile score or low percentile score. This test also gives an indication of present and potential maladjustment of the individual. The extremes of personality traits included in this test are: seriousness — impulsiveness; firmness — indecision; tranquility irritability; frankness — evasion; stability — instability; tolerance — intolerance; steadiness — emotionality; persistence — fluctuation; and contentment — worry.

Procedure

Following the medical, psychiatric, and psychologic evaluations, the experimental group was administered 50 mg. of hexacyclonate three times daily for a month, and the control group received an identical-looking placebo for the same period of time. Group psychotherapy was also initiated for a double purpose: (1) to notice any change in mental-emotional reaction of the patient; (2) to guide the patient to a more realistic approach of his environment and a better self-understanding.

At the end of the experiment the subjects were re-evaluated by the same criteria, and the same psychological tests were repeated.

Results

In considering the results of our study, particular stress was placed on the symptomology which characterizes the pattern and behavior of alcoholism, i.e., an increasing impoverishment of mental resource, increased difficulty in comprehension, hostility, aggresiveness, jealousy, and paranoid behavior.³ Improvement in these criteria was determined at weekly intervals and summarized at the end of the evaluation (see Table I). With marked or moderate considered successful and minimal and none as poor results, 10 treated with hexacyclonate were improved, as compared with one treated with placebo; nine patients on the placebo revealed minimal or no results, and one patient on hexacyclonate had minimum results.

TABLE I-OVER-ALL SUBJECTIVE RESPONSE TO HEXACYCLONATE AND PSYCHOTHERAPY AND TO PLACEBO AND PSYCHOTHERAPY

Re- sponse	No. of Patients on Drug	Per cent on Drug	No. on Placebo Drug	Per cent on Placebo Drug
Marked	8	72.72	0	0.00
Moderate	2	18.18	1	10.00
Minimal	1	9.10	4	40.00
None	0	0.00	5	50.00
TOTALS	11	100%	10	100%

Post-treatment meanscores on the SRA Mental Ability Test indicate that hexacyclonate brought about a definite, statistically significant improvement in the patient's mental speed and reaction time to solve problems, to foresee and plan, to use initiative, and to think more quickly and creatively. The treated group advanced from an average mean of 7.32 percentile before treatment to 16.00 percentile after treatment. Those receiving placebos advanced from 3.2 to 3.5.

There also was a definite tendency for the personality traits to be closer to the midline (50 percentile) following the administration of the drug, as compared with little or no change in the placebo group. The medication seemed to stabilize and balance the emotional upsets of the treated group; this was not true of the placebo group. Under therapy patients became more relaxed, more cheerful and amiable, much more amenable to medical treatment, and easily responsive to psychotherapy. In general, these results were of great statistical significance, and indicative of the patient's better over-all efficiency. The whole group, except one, who have been improved by the drug, are already discharged to the community and job placement services.

Conclusion

Hexacyclonate sodium has brought a definite improvement in mental-emotional stability of the alcoholic patients in this study. They were more amenable, the males were more respectful toward the nursing staff, and the females were less demanding of attention and sympathy. They were all less hostile and less noisy among themselves and more prone to take part in group activities or discussions of their own problems. The characteristic alcoholic ward environment of tension, impulsiveness, restlessness, adolescent noisiness, and aggression was appreciably diminished and oftentimes greatly improved. Apart from occasional drowsiness and unevenness of response, noted within the first week from the intake of the drug, the reactions were few and of mild and doubtful origin.

It must be emphasized, however, that the drug cannot replace insight and understanding of emotional problems; in this respect, its essential value lies in its capacity for reducing emotional tension and mental drowsiness, thus enabling the patient to handle stressful situations more effectively, and to make him amenable to whatever psychotherapeutic and rehabilitative measures are deemed necessary.

From these findings it appears that hexacyclonate sodium is an effective agent in treating the symptoms of alcoholic behavior, improving both mental efficiency and emotionalsocial interaction. These patients also appear to benefit physically; they seem to eat better and become more cooperative. A much improved psychomotor response is also noticed. The drug appears to be essentially nontoxic, enabling the physician to secure better therapeutic results, both physiologic and psychologic, with his patients.

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Benign Intraductal Papilloma of the Male Breast: Case Report

KHALID M. DURRANI, M.D., Chicago

A PALPABLE, BENIGN intraductal papilloma of the male breast occurs rarely. If those of microscopic size and papillary carcinomata are excluded, only two cases of this condition have been reported in the literature.

Angerer¹ reported a case of intracanalicular papillary adenoma with bleeding from the nipple in a 55-year-old male but did not mention the size of the growth. Bucher and Surver² also reported a "true duct papilloma" in a case of gynecomastia but failed to give a gross description of the lesion. Treves, et al.,3 in a survey of 30 cases of nipple discharge in the male list four cases as being due to benign ductal papillomata, but do not describe the lesions in greater detail. Benett,⁴ also reported a case of a palpable intracystic papilloma of the breast with early malignant change in a 64-year-old male, was able to find only two other such cases in the literature. Moore, et al.,5 recently described three cases of benign papillomata in the male but all were of microscopic size.

Case Report

A 69-year-old Negro male was admitted on August 24, 1961, with a history of bloody discharge from the right nipple about three years' previously and again two weeks prior to admission. He had had a retropubic prostatectomy, with bilateral vasectomy, for a benign prostatic hypertrophy three years before admission. This operation had been followed by atrophy of the right testicle, probably due to surgical trauma to the vessels.

Physical examination revealed a normally

From the department of surgery, West Side Veterans Administration Hospital, Chicago developed male. In the right breast two or three cystic nodules from 0.5 to 1.0 cm. in diameter could be felt under the medial margin of the areola, pressure over one of these producing a few drops of a yellowish-pink discharge from the nipple. The right testicle was atrophic.

Microscopic examination of the nipple discharge showed occasional histiocytes and lymphocytes with no neoplastic cells. Smears of the buccal mucosa showed a male sex pattern. The 24-hour urinary 17-ketosteroids were 6.3 mg. in a total volume of 930 cc. (normal in the male: 10-20 mg. per 24 hours). The 24-hour urinary gonadotropins showed a low normal titer. The patient was unable to provide a specimen of semen.

On September 7, 1961, simple mastectomy with preservation of the nipple and areola was performed. The specimen revealed a polypoid growth 4 mm. in diameter in an enlarged duct just beneath the nipple. Microscopically, a typical intraductal papilloma in a dilated duct was recognized (Figs. 1-4).

Discussion

Geschickter⁶ has described one case of a palpable, benign intracystic papilloma in a man aged 42 and Moroney⁷ reported a similar lesion in a 31-year-old male. In the latter case the lesion had bled intermittently for two years before the patient presented himself for examination, and was treated by limited resection of the involved portion of the breast.

Intraductal papilloma is usually a lesion of the female breast, measuring from microscopic size to over 10 cm. in diameter, and situated in the central part of the breast. It is frequently associated with a sanguineous or serosanguine-



FIGURE 1. Large duct lined by small cuboidal cells, forming small ingrowths. Papillomatous growth in center is made of compact branches lined by similar cells, mostly in single rows, and with dark nuclei. Stalks supporting the epithelium are slender and contain few capillaries. Uniformity and regularity of the epithelial cells indicate benign character of the growth. (X 100).

ous discharge from the nipple. In the male, the majority of intraductal papillary hyperplasias are microscopic. They are often associated with gynecomastia. The discharge can be developed by pressure over the palpable tumor, or by stroking along the duct harboring the papilloma. Transillumination, which may be of help in localizing the lesion in the female, is usually impractical in the male breast. Mammography, used by some⁸ to localize the lesion

FIGURE 3. Area of implantation of the papilloma. Growth is intraductal and does not involve the stroma. Formation of tubular structures, lined by cells of uniform character in single rows, is readily seen. (X 100).





FIGURE 2. Same as Figure 1, under higher magnification. (X 400).

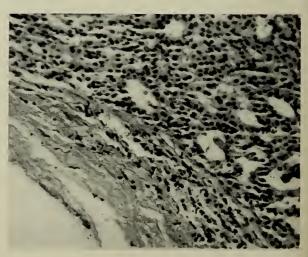
by injecting the involved duct, is liable to cause severe irritation of the tissues and is not recommended.

The etiology of this condition is not known. It is of interest to note in the case report that no endocrine abnormality was revealed by the laboratory tests.

The proper management of intraductal papillomata is highly controversial because of the following:

- 1. Nipple discharge, the commonest presenting symptom, may occur in both benign and malignant lesions.
- 2. Differentiation between benign and malignant tumors may be difficult, even microscopically.

FIGURE 4. Same as Figure 3, but under higher magnification (X 400).



- 3. Papillary lesions are multiple in almost 20 per cent of cases.
- 4. Although denied by some authors, the possibility of malignant change in a benign papilloma cannot be entirely ruled out.
- 5. Carcinoma may co-exist with a benign papilloma.

It is generally agreed that where an intraductal papilloma can be well localized in a female breast, the treatment of choice is resection of the involved duct alone. Where it cannot be localized, the sector of the breast from which the discharge can be produced on pressure should be excised. Further treatment will be necessary if a carcinoma is found on

microscopic examination. Simple mastectomy is justifiable in the male, or in multiple lesions in the female, or where the papilloma cannot be adequately localized.

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Surgery for Vascular Occulusion

From these statistics and those of other authors, we may be able to determine what type of patient is most likely to benefit from surgery. He is under 60, has a "stuttering" display of neurologic signs, and has only a partially occluded carotid artery by arteriography. We believe that his chance of avoiding further neurologic deficit postoperatively is excellent if proper management of his diet, including the amount of cholesterol ingested, is carried out. It is possible that his vascular disease may progress, for there is no real proof that lowering his serum cholesterol will materially affect his atherosclerosis. Our follow-up observations are inadequate. We are aware of the natural improvement of the patient with a vascular occlusion. The burden of determining whether surgery is more efficacious in preventing the crippling effects of thrombosis than the so-called conservative approach of anticoagulant therapy, carbon dioxide inhalations, whisky ingestion, bed rest, and stellate blocks lies solely with us. Robert G. Fisher, M.D., and Ernest Sachs, Jr., M.D., Carotid Artery for Cerebrovascular Accident. Geriatrics. October 1961.

Molecular Changes

The research chemist designing a new drug might be compared to a baseball manager who is forming a new and (hopefully) winning team. The chemist's "players" are the atoms that make up the molecule of the new substance. The characteristics of the substance are determined not only by the kinds of atoms contained in the molecule, but also by the way the atoms are placed, in other words the "positions" they play. If a baseball manager puts his center fielder on short and his shortstop in center field, he has not changed the composition of his team, but he may have greatly increased or lessened its effectiveness. If he fires the center fielder and hires another, he has changed the composition very slightly, but this slight change may have profound results - particularly if the new man is Mickey Mantle. The chemist, however, has more leeway than the baseball manager, for he can use any number of players when he tries to come up with a winning combination. Editorial. Molecular Mayhem. New York J. Med. Nov. 15, 1961.

Flurandrenolone, A New Topical Corticosteroid

M. PAUL LAZAR, M.D., Chicago

TOPICALLY USED HYDROCORTISONE has become a standard for the topical treatment of many inflammatory dermatologic conditions. With this in mind, the efficacy of a new topical therapeutic compound was compared against the performance of hydrocortisone.

This corticosteroid, flurandrenolone,* with the formula 6d-fluoro, 16d-hydrox-hydrocortisone 16,17-acetonide incorporated in 0.05% concentration in a cream and ointment was measured against the performance of 1.0% hydrocortisone in identical vehicles. Only letters identifying each of the four preparations were available to the investigator and patients when the preparations were dispensed. After completing the clinical observations and recording the data, the identity of each preparation was revealed and affixed to the appropriate situation.

Conditions selected for treatment were those which normally respond favorably to topical hydrocortisone preparations (see Table 1). This not only helped in evaluating the efficacy of flurandrenolone, but also served as a control on the physiologic and allergenic effects of the vehicles.

Study

One hundred five patients, 35 males and 70 females, ranging in age from 8 months to 70 years were treated with 0.05 per cent flurandrenolone cream and ointment with 1.0 per cent hydrocortisone in the same vehicles serving as controls on contralateral areas. Selection of cream or ointment was based on the criteria used daily in the treatment of various dermatoses occurring in ambulatory private patients. In this study, the cream was used more frequently because of its cosmetic elegance, the

condition of the dermatoses, and because treatment was undertaken during warmer weather when allowances for sweating make creams generally more useful than ointments. Cosmetic acceptability — never to be underestimated — is of utmost importance, as many therapeutic failures result from a remedy not being used often enough because of an undesirable messiness of ointments.

In determining the success or failure of the preparation, an endpoint had to be selected representing a favorable response. For example, if control of symptoms and signs by repeated topical applications was possible, the result was considered excellent or good. This judgement was based on the experience that control rather than absolute cure follows the use of any topical steroid except in "self limited" dermatoses such as poison ivy dermatitis. Therapeutic failure means either misdiagnosis, improper selection of the vehicle, an unexplained reason for the lack of response (failure), or exacerbation of the dermatitis despite treatment (failure). Inability to immediately affect postinflammatory hyperpigmentation or hypopigmentation (pityriasis alba type of atopic dermatitis) were not considered failures as, ordinarily, they would not be changed by treatment over a short period.

Experience becomes most important in a study with interpretation involving individual judgement, something always open to question. It is realized that the intensity of the dermatitis may not be equal or respond exactly the same on both sides of the body, normal exacerbations and remissions of the disease occur and unilateral improvement resulting in contralateral improvement are never completely controlled. Finally, use of the preparations may not be done as directed and outside influences (work, humidity, etc.) affect the results.

Despite such problems and objections to the structure of the study, these preparations even-

Supplied as CordranT.M. Cream and Cordran Ointment by the Eli Lilly Company, Indianapolis.

tually will be used primarily by ambulatory patients in normal life situations (school, work, etc.) and the evaluation of their worth in some respects seems better done in private practice than on indigent clinic or hospitalized patients.

Comparison of Results

In this study flurandrenolone compared very favorably with hydrocortisone. Generally, the response of signs and symptoms to flurandrenolone was more dramatic and more rapid. Itching frequently stopped after the first application or a day's treatment; most irritations would disappear in 24-72 hours. Hydrocortisone produced the same general results but not as dramatically or as rapidly. After one to two weeks, the results on both sides were comparable, with any noticeable difference being almost always in favor of the flurandrenolone preparations. However, in at least 75 per cent of the cases, it was clearly evident that hydrocortisone would need at least one week to effect results equal to those produced by flurandrenolone in 24 to 48 hours. It is possible the vehicles may make these compounds more or less effective than they would be in other bases. This may be one factor explaining why some patients responded better to this 1.0 per cent hydrocortisone cream than other 1.0 per cent hydrocortisone preparations used previously or since. No direct study was done and this represents a clinical impression.

Evaluation of the effectiveness of topical corticosteroids is best divided into two groups:

1. Dermatitis due to primary irritants and allergic reactions which may be cured if avoidance or removal of the contactant is possible in conjunction with the use of the topical medicament. Often other aids such as systemic antiprurities and other topical remedies (compresses, etc.) must be used to affect a cure.

2. Dermatoses requiring medication to control or manage the problem as is necessary with many general medical problems (i.e. insulin for diabetes mellitus, antihistamines for hay fever, diuretics and digitalis for cardiac failure with fluid retention). The most commonly treated dermatitis in this group was atopic dermatitis, well-known for exacerbations and remissions. Cure in the absolute sense should not be expected in treating this condition; control of the

Table 1.	
Diagnosis	Number of Patients
Atopic dermatitis	68
(synonymous with disseminated neuro- dermatitis, infantile eczema, flexural eczema, Besnier's Prurigo)	
Eczematous dermatitis in diaper area with "id" reaction (diaper rash)	1
Contact dermatitis (primary irritants)	7
Varicose eczema with "id" reaction	2
Lichen simplex chronicus	2
(synonymous with localized neuroderma- titis, lichen vidal, pruritus with licheni- fication.)	
Candida albicans infection (?)	1
Contact dermatitis	7
Dermatophytosis with eczematous "id" reaction	2
Infectious eczematoid dermatitis	1
Dyshidrotic eczematous dermatitis	1
Seborrheic dermatitis	7
Recalcitrant pustular eruption on palms and soles	2
Nummular eczema	1
First and second degree burns from ultra violet exposure	- 1
Intertriginous psoriasis	1
Rosacea (scaling dermatitis and pustules) _1

disease and its symptoms with maintenance therapy that requires the least expense and attention with a cosmetically acceptable preparation should be the goal in view of our present knowledge and methods of treatment. Other aspects of treatment, whether psychiatric, allergic or environmental, should be used as indicated.

These concepts were borne in mind when evaluating the effectiveness of flurandrenolone and other topical steroid preparations in this study.

Clinical Response

Flurandrenolone creams and ointments were highly effective in treating primary irritant dermatoses such as eczematous hand dermatoses seen in housewives and workers handling irritants. This was also true in diaper area eruption, primarily due to wetting, friction from the diaper and sweating due to occlusion. Response also was good in allergic, eczematous contact dermatitis without marked vesiculation. With gross vesiculation present, the additional use of wet dressings shortened the time neces-

105

TOTAL

Table 2	
Results	Number of Patients
Excellent	47
Good Partial improvement	45 12
No improvement	3

sary for cure; it seems that in the conditions topical steroid lotions, creams and ointments are no more, and often less, effective than a good shake lotion.

Control or management therapy was effective and most important in atopic dermatitis (disseminated neurodermatitis), lichen simplex chronicus (localized neurodermatitis), seborrheic dermatitis, intertriginous eczematized psoriasis, infectious eczematoid dermatitis, intertrigo, eczematous dermatitis associated with vascular difficulty (varicose eczema), and pruritus with and without perianal and/or vulvar dermatitis. Only rosacea, one case of atopic dermatitis and one of pustular eruption of the palms and soles did not improve. Perhaps some of the partial improvement seen was due to vehicle effect, rather than the active ingredients per se. Results are summarized in Table 2.

Side Effects

No clinical evidence of primary irritation or allergy to the preparations was noted. Burning was reported following initial application of the cream by one patient but this sensation disappeared, despite continued use of the remedy. No manifestations of systemic toxicity occurred; this included continuous use over at least 80 per cent of a two-year-old boy's body for at least four months. All patients were instructed to use both preparations three to four times daily and effectiveness was not impared by continued use of the preparations over a period of weeks. Lack of response would result from a change in the character of the eruption, requiring a different vehicle for a continued desirable result.

Other Clinical Studies

Treatment of 105 patients with flurandrenolone cream and ointment (plain and with neomycin) as well as 45 patients treated with flurandrenolone lotion (plain and with neomycin) has been supervised over the past year. The results with the lotion have been generally excellent, similar to those in the hydrocortisone-controlled study with no evidence of systemic toxicity, local irritation or allergy being noted.

Conclusions

In 105 patients, 0.05 per cent flurandrenolone cream and ointment was as effective or more so than 1 per cent hydrocortisone in the same vehicles. Flurandrenolone preparations, in most instances, would control the symptoms and dermatitis more rapidly and effectively than hydrocortisone; with continued application, hydrocortisone and flurandrenolone treated areas would generally show the same response. In another study, 128 patients treated with flurandrenolone lotion, cream, and ointment without the hydrocortisone control demonstrated that the preparations are safe and effective for clinical use.

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Treating the Alcoholic

One hundred alcoholic patients in a penal institution, where 65 per cent of the population are acutely alcoholic, were treated with methocarbamol for relief of skeletal muscle hyperactivity. The regimen consisted of 1 Gm. of methocarbamol intravenously on the first day; 2 Gm. intravenously on the second day; and 3 Gm. intravenously on the third day. On the fourth and fifth days the patients received oral methocarbamol, 2 Gm. four times per day. On the sixth and seventh days the total oral dosage was reduced to 6 Gm.

The results of this study show that methocarbamol is an effective medication for the relief of skeletal muscle hyperactivity in acutely alcoholic patients. Muscle hyperactivity and tremor were completely controlled in 95 patients, and only a slight tremor persisted in 3 others after seven days of treatment. Two patients could not be evaluated because of acute delirium tremens. Joseph J. Lofaro, M.D. Treatment of Acute Alcoholism with Methocarbamol. New York J. Med. March 15, 1961.

The View Box

Franz Gampl, M.D., Chicago



FIGURE 1. Roentgen examination of the skull, posterioranterior view.



FIGURE 2. Roentgen examination of the skull, right lateral view.

The patient, an eighteen-year-old male, was admitted with severe frontal headaches. These had persisted for the last four days and were of varying intensity. There was nausea and vomiting of two days' duration. He denied any trauma, but stated that he had been confined with an upper respiratory infection one month prior to admission.

The physical examination revealed a lethargic, well-nourished and well-developed male. Pulse 64/minute and regular. Blood pressure 120/70, temperature 100.6° F. The patient held his neck in moderate hyperextension. Passive flexion was limited by pain. Kernig's and Brudzinski's sign were absent. The cranial nerves and ocular fundi were normal. The deep tendon reflexes were hypoactive bilaterally. Abdominal and cremaster reflexes were absent on both sides.

The spinal fluid was clear. In sitting position, the opening pressure was 310 mm.; the closing pressure was 240 mm. of water. The Pandy test showed traces of clouding. There were 57 lymphocytes per cubic millimeter of spinal fluid. The reducing substances and the spinal fluid chlorides were within normal values. The white cell count in the peripheral blood was 4700.

What is your diagnosis?

- 1. Meningioma
- 2. Ethmoid sinusitis
- 3. Skull fracture and subdural hematoma
- 4. Brain tumor

(continued on next page)

From the radiology department, Cook County Hospital

555 for May, 1962

The View Box — diagnosis and discussion

(continued from preceding page)

The diagnosis is ethmoid sinusitis on the right.

An enlargement of the frontal area shows marked clouding of the right ethmoid cells. This finding, together with the clinical features, made the diagnosis of an ascending intracranial infection probable. While awaiting exploration the patient developed a fulminant clinical picture with left hemiparesis and died. On autopsy, a large right sided subdural abcess covering the base of the frontal lobe and the inferior portions of the temporal lobe was found. The right ethmoid cells were filled with creamy pus.



FIGURE 3. Ethmoid sinusitis on the right.

Discussion

Intracranial complications of acute sinus infections are uncommon since the advent of the antibiotic era. Trauma or surgical procedures may open pathways for an ascending infection. The superior ophthalmic vein and the perineural sheaths of the olfactory nerves are alternate routes by which an ethmoid sinusitis may pass the physiologic barrier. Depending upon localization and manner of spread, sub- and-epi-dural abscesses, meningitis, encephalitis, brain abscess and thrombosis of the carotid sinus will complicate the picture. Streptococci,

bacillus influenzae, staphylococci, pneumococci and meningococci are the most commonly demonstrated organisms. The early clinical picture may be nondescript. Close scrutiny of the routine skull radiographs which may demonstrate the clouded sinus will aid in establishing the correct diagnosis in these patients.

Prompt surgical drainage of the affected sinus and administration of the specific antibiotic are important.

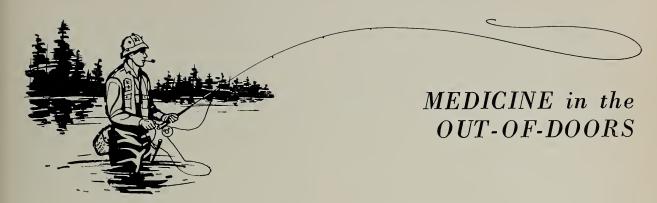
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Single-Unit Transfusions

Reports from other clinics indicate that the administration of single-unit transfusions is a common practice. Allen and his colleagues reported a 36 per cent incidence in Chicago, and Hoxworth mentioned a 30 to 40 per cent frequency in Cincinnati. The figure of 36 per cent for the period of this study may be compared with a 44 per cent incidence of single-unit transfusions on this service during a four-month period shortly before this investigation began. The 8 per cent reduction during the study period possibly reflected a more careful review of blood needs by the staff.

Retrospective evaluation of blood use is a matter of opinion, with considerable room for individual differences in interpretation. However, with the use of the criteria set forth, it was discovered that at least 34 per cent and perhaps as many as 72 per cent of the single-unit transfusions in adults might have been omitted. In the interpretation of this observation it is evident that the use of whole blood has become to some extent a routine procedure rather than a carefully considered step in the management of the individual patient. John H. Morton, M.D. An Evaluation of Blood-Transfusion Practices on a Surgical Service. New England J. Med. December 22, 1960.



The Hummer

Julius M. Kowalski, M.D., Princeton

"They are too delicate and unfitte to begine new plantations and collonies that cannot enduer the biting of a muskeeto."

> — Answers to Objections Made Against the Plymouth Colony Jan. 24, 1623.

The best laid plans for many elaborate evening lawn parties are regularly dashed each summer by the invasion of unexpected hordes of mosquitoes. They often disrupt our anticipated pleasures, striking suddenly in overwhelming numbers. Our egocentric position is then quickly propelled into orbit or completely shattered. Though insects have maintained a most important place in the ecology of land for hundreds of million years, we are inclined to agree with Maeterlinck's observation that ". . . the insect seems to be alien to the habits, morals and psychology of this world, as if it had come from some other planet, more monstrous, more energetic, more insensate, more atrocious, more infernal than our own."

Mosquitoes as a family (Culicidea) are world-wide in distribution, numbering upwards of 1,600 species, and are responsible for more mammalian mortality and morbidity than all fauna combined. Their pestiferous, annoying aspects, several other characteristics, and some surprisingly effective preventive measures

against them will be discussed here.

Mosquitoes are found everywhere except over the polar icecaps, in most arid deserts, and at elevations over seven thousand feet. The tropics have their share, but in the north country, and particularly in the arctic, their skydarkening clouds stagger the imagination—myriads over every acre, above every square mile for thousands of square miles. Incomprehensible!

In the interior of Alaska where the transition from winter to summer is sudden, lengthening sunlight hours and pleasing warmth come on with a rush; stupefying cold and snow give way to verdant green, the song of birds, the crackling rumblings of earthquakes and the everlasting, monotonus hum of mosquitoes. They are everywhere at once, as if called up by a genie bent on instantaneously squaring the account for all of mankind's transgressions through the ages — vicious, persistent, overwhelming. Just a few months earlier, one thought the bloodcurdling cold that made every

breath a searing blast within the chest was interminable. But now 300 mosquitoes would gorge themselves on a bare man's back in only 60 seconds. One's colleague, if retiring for the night and not exercising every precaution against the pests, will awaken with facial features totally unrecognizable for all the swelling — a balloon face, balls for ears, slits for eyes and mouth.

A few fools, having thoughts of proficiency at the rifle range, are deterred by the quaking, inky soup that obscures gun sights and targets. One hopes for a 40-40 — a drop in temperature to 40 degrees or a 40 mile an hour wind, or both, to put down the pests and bring back a few hours of tolerable existence.

The female mosquito must ingest a blood meal before she can produce viable eggs to perpetuate her species, and nothing shall deter her from this assigned task. Males are shortlived and obtain sustenance from plant juices. Her life span is measured in days to several weeks, and in that time she will produce as many as six batches of eggs. These are laid in or near water (fresh or brackish), on damp soil, or in depressions where moisture will at some future time accumulate. This explains in part why mosquitoes literally spring up from even the best groomed lawns after prolonged rains. The eggs are impervious to frost and in some species withstand desiccation for years. The life cycle from egg through moults to adult is measured in days to weeks, depending on the species.

Mosquitoes are fragile, and as a rule will not fly about in air currents of breeze velocity or stronger. Some salt-marsh varieties, however, are strong fliers and travel regularly several miles in a stiff breeze. The flying range for most mosquitoes is about one mile or less. Except in the north country, mosquitoes are aphototactic (avoid direct sunlight) and become most active at sundown and for several hours thereafter. But they will attack mammal, bird, reptile or amphibian at any time in their shaded abodes. This swarming, a nuptial act, is often repeated at dawn. Some species prefer the former period to the latter; others are active at both times. Swarming can take place a few feet above the ground or as high as 40-50 feet.

Mosquitoes possess a keen sense of smell and are especially receptive to body odors of mam-

mals. Most persons readily attract mosquitoes, but a few fortunate ones only moderately so. The successful strides in repellent development have been along these lines — by masking or destroying body odors or disrupting this perceptive mechanism in mosquitoes for odors. Smoke remains an effective repellent. It was the prime defense for the Indians and pioneers. Notes in the Lewis and Clark expedition journal describe their heavy all-night smudges. The tearing eyes, running noses and stifling coughs from smoke were a welcome alternative to incessant nightly bloodletting attacks.

The destruction of mosquitoes and their habitat is an awesome undertaking which calls for funds, equipment and the services of many thousands. It is a top priority project of the World Health Organization. In spite of all these efforts, malaria still claims more than 2 million lives annually. For our purposes, however, the usual picnicker, camper or fisherman can set loose a lethal bolt of insecticide from an aerosal can. For all the effectiveness of DDT and pyrethrum against mosquitoes 15 years ago, the immutable forces of natural selection and adaptation are presently evolving resistant forms, and the development of new insecticides will remain an unending process.

In the midwest, one need not be denied the many pleasurable activities of the outdoors if several basic facts are kept in mind. The mosquito population peaks in late spring and early summer, but it may remain high if rains persist. They are most active during early morning hours and at dusk; they are attracted to faint light and light-colored clothing.

In or near the mosquito habitat adequate screening is essential — at least 16 mesh. Spraying cabin, trailer, tent or home about one-half an hour before sundown and again before retiring should be sufficient if screened windows and doors fit properly and all cracks in walls, floors and ceilings are sealed. Often at dusk, when the air is calm, mosquitoes will be found resting on screens of windows and doors; spraying them every day with insecticide and repellent will reduce the population.

Since most mosquitoes are restrained by winds, it is desirable to pick a spot such as a peninsula or elevation for a summer cottage or camp, or where prevailing winds are likely.

In established areas, the air can be kept sur-

prisingly clean of insects by having a colony of martins or swallows nearby. Stomach counts reveal that as many as 300 mosquitoes can be consumed by one of these birds in an hour; 50 of them at work in a given area from dawn to dusk all summer would be worthwhile.

Wearing of appropriate clothing is the first line of defense against mosquitoes. This means trousers, *heavy* trousers — sometimes two pairs. Also, one or two pairs, if necessary, of long heavy socks and footgear that protects the ankle or slightly above. Heavy shirt or jacket, hat with adequate netting (16 mesh or finer) to protect face and neck, bandana handkerchief around the neck, and canvas or leather gloves complete the outfit. Now, this might not be the

most comfortable gear to wear on a hot, humid night, but it sure is insect-proof.

Present insect repellents are effective, one having been on the market since World War II and the other for about four years. New ones are in continuous development; the most promising recent one repels most insects effectively, and in addition, sticks well to wet skin. This is a limitation of former products. No repellent is effective if used only sparingly. It should be used generously on the legs and ankles, hands and wrists, back of neck and head.

Thus clothed, dripping with sweat and saturated with insect repellent, a man can go forth in the bush country and get a tremendous number of mosquito bites.

Sublingual Therapy

Nitroglycerine 0.6 mg. was administered sublingually to 11 patients during acute episodes of bronchial asthma. Three of these were unresponsive to intravenous aminophylline 0.5 gm. given one and a half hours prior to nitrite therapy. Their ages ranged from 26 to 52 years, eight women and three men. One second timed vital capacities were recorded by means of a simple timing attachment to the ordinary dial type vital capacity machine prior to medication and 10, 20, 45, 60, and 90 minutes following. In all cases except one, who refused to perform the function tests, there was improvement in the one second vital capacity. All 11 patients showed subjective improvement.

Three patients with bronchial asthma varying

from 6 to 18 years were given erythrol tetranitrate 15 mg. sublingually and tested by the same method. A one second timed vital capacity was performed prior to medication and 10, 20, 45, and 60 minutes following. They were then placed on a regimen of erythrol tetranitrate 15 mg. orally three times a day for six days. Increased timed vital capacity and subjective improvement was noted in all.

Two patients were given nitroglycerine 0.6 mg. sublingually, and the one second vital capacities were recorded by closed method spirometry. This was later repeated with orally administered nitroglycerine. These results indicate that the two methods of administration have equal therapeutic value. Irving Hirschleifer, M.D. and Yogesh Arora, M.D. Nitrites in the Treatment of Bronchial Asthma. Dis. Chest. March 1961.

Mumps and Congenital Defects

Although normal children were delivered in the majority of cases reviewed, mumps during pregnancy can cause maternal morbidity and mortality, abortions, still births, and congenital defects.

In most cases the abortions, stillbirths, and congenital defects result in those cases where the mother had mumps in the first trimester, although in one case a woman contracted mumps when she was seven months pregnant and later delivered an infant with mongolism.

Of the 95 infants born of 94 mothers with mumps slightly less than 16 per cent had congenital defects; almost 15 per cent of the pregnancies ended in abortions or still births while slightly more than 69 per cent of the infants were normal. Herman W. Hyatt, M.D. Relationship of Maternal Mumps to Congenital Defects and Fetal Deaths, and to Maternal Morbidity and Mortality. Am. Pract. & Digest Treat. May 1961.

American medicine currently is engaged in a life-and-death struggle with nationalized medical legislation. If any of us doubts that such legislation would thwart the high standards of quality and individual initiative in medical practice which we now enjoy, we need only observe the plight of our British colleagues. Nationalized medicine has been practiced in Britain for 13 years, during which time the medical standards of that country have sunk to catastrophic lows. This sad experience, related here by a noted British medical economist, should serve as impetus in our fight to avoid the same fate. The Editor.

Nationalized Medicine in Britain: The Winds of Change

JOHN R. SEALE, M.D., M.R.C.P., Richmond, Surrey, England

The current proposal to finance medical care for the elderly in the United States by use of the social security tax spotlights recent developments in the nationalized health service in Britain. Medical care of all forms was provided in Britain in 1948 by the Labor government. The State provides medical care free of charge to the entire population irrespective of income. There are only nominal charges of 30 cents for prescribed drugs and small charges for dental treatment. The central government found it necessary to nationalize the private and city hospitals. Specialists are paid a salary and general medical practitioners receive a modified form of salary. Although the state health service is partly financed by compulsory insurance payments, nearly 80% of the cost has been covered by general taxation.

Free medical care is a very attractive proposition to the people and it had immense support from the general public and from the national press at the outset. In 1946 the British were

From the British National Health Service

From a talk sponsored by the Chicago Junior Association of Commerce and Industry, March 23, 1962. Condensed for publication by Walter L. Oblinger, Counsel for the Illinois State Medical Society emerging from a world war with its six years of control over the individual by the State, creating a favorable climate to the passage of the N.H.S. bill. In recent months, however, several economists have been questioning the basic arguments for nationalizing medicine and there is a growing awareness that the wholesale nationalization of medical care fourteen years ago was a mistake.

The shifting of medical care costs from the patient to the taxpayer has not eliminated the fact that nurses, doctors, dentists and other health workers still have to be paid for the services they provide. Taxes are no more popular than direct payments for medical care.

Built-in pressures on the taxpayer have resulted in so much attention to keeping down costs that the quality of service is being affected. Efforts to provide medical care of the quality and quantity acceptable to the electorate and, on the other hand, to limit expenditure of tax funds as much as possible, has posed a dilemma to the government. The two objectives tend to be mutually exclusive. To date the most articulate public critics of nationalized medicine have levelled their attacks at high cost rather than low quality. It has been considered politically inexpedient to raise substantially the cost to the patient, but great efforts have been

directed to curtailing expenditure on the service itself. To keep costs down the aims have been to have economy with efficiency; however, economy in practice often means cheapness, and this carried too far tends to impair efficiency.

Capital expenditures have been found to be the easiest way to economize, and the first casualty in the economy campaign was the hospitals. One of the primary arguments in favor of nationalizing the hospitals in 1946 was that capital expenditures on them under the old system had been inadequate, and that after the damage and neglect of the war years only the State could afford the huge capital investment required to modernize them. Nevertheless, annual capital expenditure on the hospitals in the first six years after nationalization at constant price was only one-third of that spent in the 1930s. The proportion of the total capital investment of the nation devoted to hospitals, already so low in 1949, has fallen substantially since then. It has not been until 1962, 14 years after the state monopoly was created, that detailed plans for a major rebuilding of the hospitals have been put forward. Forty-five per cent of our 4,000 hospitals are over 70 years old, and 21 per cent over a century old. Only one new hospital has been completed since the end of the war, although another 20 or so are under construction. Much of the energies of doctors and nurses, as a result, have been wasted as they work in inefficient surroundings.

A policy of stringency tends to lower the incomes of those who work in any organization dominated by this aim. Most people believe that governments spend the money raised by taxation lavishly, but it must not be forgotten that the State can be mean as well as generous. The State has in fact used its immense power over doctors to obtain their services inexpensively.

According to economist D. S. Lees, the real incomes of general medical practitioners between 1950 and 1959 fell by a fifth, while those of the community in general went up by about as much. Even with the much publicized increase in doctors pay in 1960 they are still no better off than they were ten years ago. This can be said of few other sections of the British working community and contrasts strongly with

the trend of medical incomes in most other countries. Furthermore, *The Economist* recently pointed out that the average real earnings of general practitioners last year was only 76% of what it had been in 1938.

Probably more important than the fall in real incomes of any particular grade, however, is the rapid expansion of medical appointments with low salaries compared with expansion of those with high salaries. Between 1953 and 1960 the number of senior, relatively well-paid specialists increased by 8 per cent, while the number of residents and interns increased by 21 per cent. The number of senior specialists in general surgery in the last nine years, however, actually has been reduced. The result has been that surgeons have remained in junior posts (called registrars) on low pay for many years indeed often till middle age. The usual age for becoming a consultant has been about 38, many specialists have continued as registrars into their 40's, and many others have been able to obtain permanent employment by emigration. During the long years as a registrar the surgeons have often been undertaking, according to a recent government report, the same work as a consultant. However, the salary of a registrar is only about half that of a consultant. Increasingly, the demand for doctors in the nationalized hospitals has been for those who are willing to provide their services for low prices.

Many young doctors are unwilling to accept the cut prices offered for their services. They have found that a vocation by itself is inadequate to feed, clothe and house one's children. With the State virtually a monopoly, doctors must either accept the terms offered by the State, leave the country, or leave their profession.

Large numbers have left the country. In the ten years of the 1930s, before nationalization, an annual average of 27 doctors with British degrees registered for practice in Australia. In the last five years the annual rate has been 225. The 1959 figure of 256 was almost equal to the total for the entire ten years of the 1930's. In the last eight years an average of over 200 doctors emigrated to Canada each year. More doctors trained in England and Ireland passed their State Boards examination in the U.S. in 1960 than in the whole decade of the 1930s.

In the last ten years the number of British doctors going to Australia and North America has been well over five times the rate prevailing in the 1930s, the equivalent of a third of the annual output by British medical schools. The reasons for their departure are greater professional freedom and financial returns commensurate with the years of study, the long hours of work and the heavy responsibility required of physicians.

In addition to the great loss of British doctors through emigration there has been a falling off of the number of medical students in training, from 14,200 in 1950 to 12,300 in 1959. In 1957 a government committee recommended a further 10% cut in the intake of students. As a result the number in training is now no greater than it was before World War II, despite a rise in population and increased complexity in medical practice. The doctor shortage has been further aggravated by a steep rise in the retirement of elderly physicians. Nearly twice as many doctors will reach age 65 in the next five years as did in the last five years.

To cope with the failure in supply of doctors, State hospitals are increasingly relying on doctors from overseas to take temporary posts. By 1960 41 per cent of all junior hospital posts in England were filled by doctors trained outside the British Isles. This consisted of 4,000 doctors, and the proportion is rising rapidly. In the region around Sheffield, an area in the north of England, 26 of the 74 hospitals have no doctors at all below the grade of consultant (under age 40) who were trained in Britain. Young doctors from overseas arrive with little experience, and once they become competent they return to their own lands.

Many hospitals are employing newly qualified doctors in responsible positions without adequate supervision and the tendency is to use these new recruits as "pairs of hands"—inexpensive medical labor instead of offering them training and experience under supervision.

Language also has become a problem. It is not unusual to find a doctor in a mental hospital barely able to speak English and therefore unable to communicate adequately not only with his patients but with other doctors. An official in a regional hospital board described the problem thusly, "An Indian discussing clinical matters with a Greek, both of whom have only a limited knowledge of English, has difficulties enough; but the problems become worse on the telephone when the general practitioner, perhaps in a northern dialect, tries to explain a patient's ailment to a Chinese."

The effects of prolonged stringency are now beginning to show in the nursing profession and in other health professions. The success of the state health service up to the present in providing medical care of high quality has been due to the abundant stock of human, moral and material capital which it inherited in 1948. Material capital in the form of hospital buildings and equipment has been allowed to run down and it is now becoming apparent that the human and moral capital of the health professions has also been consumed with but partial replenishment.

It is erroneous to assume that the major problem in medical care is cost. The oversimplified approach in the 1940s of removing the burden of payment from the patient ignored the greater problem of providing quality medical care.

The objective sought in any form of health system is to ensure medical care of high quality, that no individual shall be unable to obtain it for financial reasons, nor shall he be financially ruined because of medical expenses alone. These objectives can be reached without the nationalization of all medical facilities and personnel, as instituted in 1948. The State has an important role to play. In the United States, where the treatment of mental disease and tuberculosis long has been a function of public authorities, the individual also has a part to play. It is the preservation of a reasonable balance of rights and duties between the State and the individual which is the hallmark of a free but responsible society. In my country in the field of health this delicate balance has been disturbed but the realization that some change is needed is just beginning to dawn.

You may think from what I have said that medicine in Britain is in trouble; however, to assume that this is all there is to be said about the situation would be erroneous. The British may be slow to change their minds but once they realize that change is necessary they are well able to bring it about.

MEDICAL ECONOMICS



Physician Agreement— National Blue Shield Aged Plan

In answer to the need to find a positive approach to solving the problem of medical care for the senior citizen with a low income, a uniform nation-wide program of surgical and medical care benefits will soon be available. Joint public announcements of such a program were made recently by the American Medical Association and the National Association of Blue Shield Plans and received wide acclaim in the press — both here in Illinois and throughout the nation.

The American Medical Association likewise has recommended that "all state medical societies cooperate fully with their local Blue Shield Plans in implementing the program as soon as possible."

In line with this recommendation, the House of Delegates of the Illinois State Medical Society recently approved the schedule of surgical and medical care benefits to be offered under this program in Illinois. Illinois Medical Service (Blue Shield) likewise has agreed to underwrite the program.

The Society therefore is now taking steps to place the program into operation and is asking that physicians throughout Illinois support the program by signing Physician's Agreement cards which have been mailed out to every physician.

This new program follows the general pattern of the Over 65 Program outlined by the Illinois State Medical Society two years ago. However, it offers expanded benefits for members with increased payments to physicians in many instances.

The program would provide benefits for sur-

gery whether performed in a hospital or doctor's office and for medical care both in a hospital and in a licensed nursing home.

Payments also will be provided for anesthesia, radiation treatments, x-ray examinations, and for laboratory tests and pathology services.

This new program extends greatly the coverage for doctor's visits in a hospital. It provides up to 70 daily visits per admission. When there is a 90-day interval between discharge and readmission to a hospital 70 visits are again available for the care of ordinary illnesses and accidents.

While this Over 65 Program has a six-month waiting period for pre-existing conditions, it even provides in-hospital medical care for 30 daily visits per 12-month period for mental, nervous and TB cases. Where intensive medical care in a hospital is required . . . an additional payment may be made for services rendered by the attending physician for serious diseases requiring more than the usual amount of medical care.

In addition to providing benefits for in-hospital medical care, physician's care in a nursing home may include benefits for one physician's visit a week for 13 weeks immediately following discharge from the hospital.

This program is designed particularly to help persons over 65 with low incomes. To qualify for paid-in-full benefits, a single person's personal income from all sources must be under \$2,500 and the combined annual income of a husband and wife may not exceed \$4,000. Persons enrolled in the program whose income exceeds these limits may be expected to pay

the difference between the payments provided under the program and the customary fees of the physician.

Thus, this program retains free choice of physician and the right of the physician to set his own fees, for patients who are able to pay. The Blue Shield program, which is expected to cost approximately \$3.20 per month, likewise would make it possible for senior citizens with low incomes to protect themselves through the voluntary system and make a compulsory system of medical care unnecessary.

The Society believes this program can be an important step in achieving — through voluntary private enterprise — an effective solution

to problems of meeting the health care needs of our older population.

Both the House of Delegates and the Council of the Illinois State Medical Society strongly urge all physicians in Illinois to support this program. When you receive the Participating Physician's Agreement card, sent out by the Society, be sure to sign and return it at once so the program may proceed quickly.

Edwin S. Hamilton, President, Illinois State Medical Society



According to the ISMS Constitution . . .

ARTICLE VI. SECTION 1. Composition. The Board of Trustees, or as in this Constitution and Bylaws designated THE COUNCIL, whose duties are executive and judicial, shall consist of sixteen councilors elected by the House of Delegates, (six shall be chosen from district number three and one from each of the other ten districts, these districts of the geographical area as of May, 1946), and one councilor-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect and secretary-treasurer. The vice presidents, the presiding officer and the alternate presiding officer shall attend the meetings, (including executive sessions) with the right of discussion, but without the right to vote. Besides its duties mentioned in the Bylaws, it shall have charge and control of all property belonging to this Society of whatsoever nature, and of all funds belonging to this Society from whatsoever source.



Editorials

Retrolental Fibroplasia*

Possibly the most dramatic discovery in ophthalmology during the past ten years has been the demonstration of the etiologic role of excess oxygen in the pathogenesis of retrolental fibroplasia. At the time its cause and the cure was found, this condition was blinding over 1,000 infants a year in the United States; the number totally blinded by retrolental fibroplasia exceeds 7,000.

Statistics on the economic cost of blindness are not particularly trustworthy or complete, but even inaccurate figures suggest that the increased out-of-pocket cost to support these children because of their blindness exceeds \$1,000 annually for each child, or minimally \$7 million a year for this group of blind solely. With a normal life expectancy the total cost of this group to governmental and philanthropic groups will exceed \$490 million, together with an untold amount of heartbreak.

At the time the incidence of retrolental fibroplasia was increasing in this country, Campbell observed in Australia in 1951 that the disease was seen only in those hospitals in which premature infants were placed in incubators and was not seen in those institutions without incubators. This finding was quickly confirmed by Crosse and Ryan in England in 1952. Patz, Hoeck and De La Cruz, at Johns Hopkins University, then reported a controlled clinical

test which subjected alternate infants to varying amounts of oxygen and provided strongly suggestive indications that the search for the causative agent for retrolental fibroplasia might be at an end. Gyllensten and Hellstrom in Sweden, followed by Arnall Patz in this country and Norman Ashton in England, began virtually identical studies in which newborn mice, rats and kittens were placed in a high oxygen environment and subsequently developed a proliferative vascular lesion similar to in many respects, but not identical with that occurring in retrolental fibroplasia.

However, in 1952 it was by no means evident to investigators that excessive oxygen was the etiologic factor in the pathogenesis of the disease. The manifestations fluctuated bizarrely, there was a variation in incidence both temporally and geographically, and earlier studies suggesting useful methods of treatment had later been repudiated. Thus in October 1952 a National Cooperative Study on Retrolental Fibroplasia was conceived and subsequently investigators from 18 hospitals agreed to pool their nursery facilities and interests to determine the degree of association between the incidence of retrolental fibroplasia and the administration of oxygen. Additionally the study would make possible the determination of whether the survival of the premature infant was dependent upon the amount of supplemental oxygen given.

The study was so sensitively designed that not a single infant died nor did a single infant develop retrolental fibroplasia because of in-

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^{*}Guest editorial by Frank W. Newell, M.D., Professor of Ophthalmology, University of Chicago.

clusion in the study. With the data accumulated from these widely separated institutions it was shown that an excessive amount of oxygen removed the stimulus necessary for the orderly growth of blood vessels in the premature infant's eye and that with a supplemental amount of oxygen adequate to maintain life, retrolental fibroplasia was not observed. Additionally the increased susceptibility to retrolental fibroplasia of infants weighing less than 1500 grams was demonstrated.

This study might well be a classic for years to come, showing the benefits to be derived from cooperative studies of a disease condition which, although occurring sporadically in an individual institution or community, may be studied by grouping a number of institutions and investigating a significant proportion of those involved.

At present it is recommended that the decision to use supplemental oxygen be based upon the clinical indications of each individual newborn and that it not be used empirically. If oxygen is used the concentration should never exceed fifty per cent and should be less than this if possible. Periodic rather than continuous oxygen therapy is desirable, if tolerated. Oxygen therapy should be discontinued as early as possible.

Automation for Medical Libraries

The National Library of Medicine is developing a computer-based system for its bibliographic services. It is known as MEDLARS (Medical Literature Analysis and Retrieval System). The latest electronic equipment will be installed in their new library building adjacent to the Institutes of Health in Bethesda, Md.

The MEDLARS system is a bold departure from the conventional way in which medical information is stored and retrieved. It is an attempt to automate this phase of library work with an electronic system capable of a tremendous output. Specifications for MEDLARS were prepared a year ago, and contracts have been awarded to the General Electric Company. The heart of the machine is a digital computer. According to a report by the director, Frank B. Rogers, M.D., the information will be fed into the system through punched paper tape, which represents the indexing done by the

Library staff. This information will be converted to magnetic tape and manipulated in the computer. The magnetic tape so processed will be used to activate a very high-speed composing device which will be capable of producing photographic masters for printing. The Library now indexes 140,000 papers annually; MEDLARS will accommodate 250,000, and a large volume of the non-journal published information which is not indexed currently.

According to Dr. Rogers the device will have controls enabling them to sort by language, by date, by title of publication and in other ways, as well as by subject fields.

MEDLARS will serve many useful purposes. It will produce an increased high-speed composition capacity for the published Index Medicus. It can supply a periodic or recurring bibliographic listing of world references in a special field for research groups.

In addition, it will be able to retrieve on demand queries from individual research installations concerning new publications.

They expect to store 180,000 references in the electronic device during its first year of operation. The Library hopes in time to answer the long-felt needs for current awareness services to keep scientists posted on the latest developments in their fields. It should become a new key to medical libraries, especially when coupled with a photoduplication service. He expects the art of electronic typography to be advanced as a byproduct of MEDLARS.

The future possibilities of electronic storage and retrieval of medical information are most exciting. MEDLARS will provide American medicine with a powerful device for searching with unprecedented speed and effectiveness the expanding literature of medical sciences.

Mucoviscidosis

Cystic fibrosis was almost unheard of twenty years ago except perhaps as a familial and fatal disease of young children with a basic pancreatic dysfunction. The condition now has become a major health menace that ranks with rheumatic fever, diabetes, and poliomyelitis. In addition, it is recognized as a disease of adults as well as children and involves more organs than the pancreas.

The pathology can be found in the mucous

glands throughout the body, with accumulation of abnormal secretions leading to dilatation of glandular structures. Mucoviscidosis is a more acceptable term because there is an increased viscosity of the mucous secretions. No histological changes are noted in non-mucous producing exocrine glands, such as the parotid or sweat glands, even though their secretory products are very abnormal. Perspiration, for example, contains excessive amounts of salt in 99 per cent of the patients with this disease. It is for this reason that the measurement of the chloride content of the sweat is used as a screening procedure for mucoviscidosis regardless of the manifestations. A test paper has been devised for this purpose.

The disease was described originally as involving the pancreas. The symptoms of diarrhea and malnutrition were caused by the thick, heavy mucous blocking the pancreatic ducts and cutting off the secretion of enzymes.

Involvement of the lungs leads to atelectasis and emphysema, especially when trachea and bronchi are filled with inspissated material that blocks the passageways. Allergy also enters the picture because the pulmonary changes in asthma and in mucoviscidosis often show identical mucosal secretion and narrowing of the bron-

chial lumen. Cough, dyspnea, and wheezing are manifestations common to both conditions. Mucoviscidosis should be considered whenever asthma does not respond to usual therapy.

The disorder makes its debut at any age. The infant who develops the full-blown disease may die of meconium ilius or bronchopneumonia. The majority of children with the condition seldom lived more than six or seven years after the diagnosis was made, but nowadays many live through adolescence as a result of adequate therapy. Staphylococci infections are their nemesis because the organism thrives in a strongly saline medium. Pulmonary involvement often dominates the clinical picture and determines the outcome.

But mucoviscidosis is no longer a pediatric problem, and all physicians should be acquainted with the disease because of its relationship to many well-known clinical entities. Early diagnosis and treatment is essential before irreversible changes occur in the lungs. We know also that many victims develop a partial version of the disease with abnormalities of one or more organs. Involvement of the sweat glands may be the only finding, and the condition is detected, perhaps when heat exhaustion follows excessive loss of electrolytes.

Medicare According to a recent White House announcement, the 27 Deck Loaded physicians who met with President Kennedy to discuss his compulsory medical care for the aged plan all gave it their wholehearted support. Among these ostensibly unbiased discussants, described by the President as "some of the most distinguished members of the medical profession in the United States," were the following:

One was chairman of the platform Committee on Health at the past Democratic Convention; seven had testified before Congress in support of the Administration's medicare plan; one organized a "Committee of Physicians" for Kennedy during the 1960 campaign; four are officials of "citizens' groups" which have long supported the Administration's plan; three are employed by international unions which support the plan; two are New York City employees of Mayor Wagner, an outspoken supporter of the Kennedy plan; and one is the director of a hospital supported entirely by Government funds.

Of this group, none could be found who are in private medical practice. Republican Congressional Committee Newsletter, March 30, 1962.

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Patient-eye View of Doctors

The Opinion Research Corporation conducted a study for the American Academy of General Practice to determine the actual image of the general practitioner in the public eye. According to Mac F. Cahal, the ORC found that people want improvements but basically are satisfied with American Medicine. Three-fourths of the public call their family physician first when they need help and felt that good medical care is centered around a particular family physician. People want better medicine, want to pay for it and are satisfied with the fee-for-service system. They demand, however, sheer competence on the part of their physician. And finally, the key public relations in medicine, according to ORC, is to improve the group image; people already have a high regard for their own doctor.

FETAL EKG BY REMOTE CONTROL

It is possible now to obtain remote control electrocardiograms from unborn infants. Telemedics, Inc. recommends their Fetal RKG 500 for detecting fetal life during labor, operative delivery, obstetric analgesia and anesthesia, medication administered to the pregnant patient, vaginal bleeding, fetal distress, prolapsed cord and other complications of pregnancy. The electrodes are applied externally to the pregnant patient in a standard configuration. These are connected to a transmitter that broadcasts the maternal and fetal EKG's to the receiver with no connective wires. The receiver relays it to any standard recording apparatus, oscilloscope or a special magnetic tape recorder. The fetal and maternal complexes are easily distinguished on the tracing or oscilloscope.

DIRECT SURGERY FOR CORONARY OBSTRUCTION

According to a release from Warner-Chilcott Laboratories, "a direct surgical approach to coronary obstruction eventually will be developed." Drs. J. N. Burkeholder and H. E. Stephenson, after a study of 100 unselected postmortem human hearts, found "the segment of initial involvement was most often the proximal 3 cm. of a coronary artery. The anterior descending branch of the left coronary artery was usually the first to show obstruction; this was seen in teen-agers. The segments of maximal occlusion were in the first 3 cm. of the coronaries and primarily in areas of stress and at bifurcations. Myocardial segments were relatively free of disease while epicardial segments of the same artery showed a more severe atherosclerosis. Many coronary arteries were studied radiographically prior to dissection. Narrowing could be seen if the occlusion was greater than 20 per cent."

HELPING UNMARRIED PARENTS

The Department of Health, Education and Welfare urged each state to set up a system of helping unmarried parents. They have a new pamphlet on this subject that advises young unmarried women to continue studies for high school credit while in homes where they are given proper prenatal care. It calls for finding the young unmarried fathers and educating them to the point where they will be able to assume family responsibilities. The handbook also maintains that the State Department of Public Welfare is responsible for encouraging the development of a network of services throughout the state that assures every unmarried mother the help she requires.

MEDICAL GRAD CAREER CHOICES

According to Datagrams, the current trend in career choices among medical graduates is as follows: seventy-eight per cent are interested in a specialty practice, 18 per cent in general or family practice and four per cent in research and teaching. The percentage in 1950 was 63, 33 and four respectively. Surgery (general and specialties) is the most popular among the interns who intend to undertake a specialty practice. Internal medicine is next, followed by obstetrics-gynecology, pediatrics and psychiatry.

Nose Knows Best

According to a recent news release from the American Institute of Biological Sciences, "Man's nose remains unchallenged as a sensitive, bad-breath detector," and "No man-made instrument was as good as the nose for detecting odor." This is fortunate because no one is more interested in bad breath than man.

CARBON MONOXIDE AND THE DRIVER

Commander John H. Schulte, a United States Navy physician now studying at the University of Cincinnati, found that persons exposed to low levels of carbon monoxide can think as fast as ever but are apt to make more mistakes than normally. The slight impairment was not regarded as enough to excuse automobile drivers for errors in judgment in accidents. These studies were conducted because of the potential danger to personnel on the Navy's nuclear submarines which are submerged for long periods of time.

The experiments were done on off-duty Cincinnati firemen because of the possibility that carbon monoxide might impair their judgment on entering a burning building. The men inhaled carbon monoxide until the blood level was 20 per cent. This was not enough to cause symptoms, even though slightly less than the usual level reached in 30 minutes by firemen inside burning buildings.

Headache, nausea, and fatigue occurred when the concentration reached 25 per cent; loss of consciousness and death can occur when twice this level is attained but is unusual in healthy and resistant persons. The foreman made three times as many errors when the concentration was 20 per cent as before the carbon monoxide was inhaled.

FORCED ABDICATION

A Federal Court has held royal jelly worthless for a host of ailments. FDA Commissioner George P. Larrick called the action "a milestone in the constant battle against the unscrupulous promotion of supposedly miraculous products. Royal jelly is another example of the exploitation of outlandish exotic substances as miracle ingredients which has gone on since the Middle Ages," he commented.

The first contested case on mislabeling of the product was brought in 1958 against the Jenasol Company of New York City after the seizure of a substance labeled "Jenasol" or "Jenasol RJ Formula 60." The capsules were said to contain "royal jelly" and certain vitamins as active ingredients.

Jenasol labeling and literature claimed royal jelly was good for increased sexual vitality, relief from irritability, headaches, insomnia, physical and spiritual convulsions, and depression, restoration of vitality, alleviation of the ills of old age, improvement of memory, stimulation of appetite, normalization of the growth of underdeveloped children, extension of life-span, palliation of glandular activation, alleviation of the physical and mental symptoms of approaching old age, help for tired eyes, and the achievement of a pleasing state of relaxed well-being.

How brazen can some people get?

HEALTH AFTER RETIREMENT

A survey on retirement uncovered a few unsuspected facts. Two Cornell University sociologists questioned 477 men who had retired four years previously. Twenty-four per cent said their health had deteriorated since retirement; 32 per cent believed it had improved, and 44 per cent reported no changes. They also questioned 783 men of the same age group who were still working. Forty-three per cent said their health had become worse in the past four years, 26 per cent said their health had improved and 31 per cent reported no change.

PHARMACEUTICALS

Duphaston is a new synthetic substitute for the female hormone progesterone. It has proved effective in treatment of menstrual disorders such as irregular or excessive bleeding, premenstrual tension, or painful menstruation. Philips-Roxane, the manufacturer, also claims that it is of value for pregnant women with a history of previous miscarriages or in whom a miscarriage is threatened. The hormone does not interfere with ovulating and does not cure masculinizing effects on the patient or on the unborn fetus.

Doctor James G. Hirsch of the Rockefeller Institute believes that Aralen (Winthrop) may prove to be of great value in treating sarcoidosis. Doctor Hirsch treated eight chronic cases for six months and marked improvement occurred in seven patients with skin lesions. The improvement occurred within two to three months and maximal improvement in about six months.

Taractan is Roche's new psychotherapeutic drug which offers "broad-spectrum" activity in the therapy of mental illness. This thioxanthene derivative is particularly useful in severe agitated states associated with neuroses, depression, or schizophrenia.

The Upjohn Company announced the withdrawal of its psychic energizer or mood elevator —Monase—from the market. This was done because an occasional patient developed agranulocytosis.

MEASLES VACCINE EFFECTIVE IN EPIDEMIC

Lilly's killed-virus measles vaccine performed remarkably well in a Philadelphia measles epidemic last May. The three doses of vaccine were given with an interval of two weeks between each dose. Cases of measles occurring within the first two weeks were considered to result from prior exposure and to develop before any immunity could be conferred by the first dose of the vaccine.

The investigators vaccinated a total of 953 children from six months to six years old. A control group of 953 children in the same age bracket was observed during the same time. Only four cases of measles were reported among vaccinees after the first two weeks, (all

of them before the 20th day). There were 84 cases after the 14th day among the controlled. No child receiving three doses of vaccine had measles.

Lilly also announced two new, pleasantly flavored, aromatized products to control diarrhea and restore normal bowel function. The first, Quintess, is an aqueous suspension of regular and colloidal activated attapulgites and citrus pectin. Attapulgite is an unusual clay mineral which is a powerful absorbent. The other, Quintess-N, has the same formula plus neomycin sulfate.

Armour Pharmaceutical Company introduced a new convenient one dose vial of H. P. Acthar Gel last month. The one dose vial contains 40 USP units per 1 cc. of highly purified repository corticotropin. The vials are packed 10 to a box. The product stimulates secretions of all the adrenocortical hormones considered to be vital factors in the body's defense against a wide variety of stresses, such as rheumatoid arthritis, asthma and hay fever, bursitis, and a wide variety of skin and eye diseases.

Dextrotest, (Ames), a simple and rapid tablet test yielding reliable blood sugar estimations, is now packaged in a new plastic case containing test tubes, filter paper, plaster filter, and Dextrotest tablets. A clear-cut color chart is included to indicate blood sugar levels within the range of 100-400 mg./ml.

A new "pep pill" (Thozalinone) was announced recently at the American Chemical Society by Dr. Charles F. Howell. It is still in the research stage but tests to date show it is an effective stimulant without side effects. Time will tell what happens when it is used by a large number of individuals.

Doctor Edward Settel, of Brooklyn, gave a preparation of dried Lactobacillus acidophilus (Bacid) to 48 patients with gastrointestinal complaints. The conditions treated were diarrheas following use of antibiotics, proctitis (some with pruritis), others with aphthous stomatitis, spastic and mucous colitis, diverticulitis with pain and diarrhea, excessive gas. Twenty-three patients showed excellent response with disappearance of symptoms from 4 to 10 days.

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Rudolph G. Novick, M.D.

Medical Director

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for May, 1962 571

Book Reviews

WILLIAMS OBSTETRICS. Nicholson J. Eastman,M.D. and Louis M. Hellman, M.D. \$16. Pp.1,205. New York, Appelton-Century-Crofts,Inc., 1961.

A new edition of Williams Obstetrics is always an eagerly awaited event by obstetricians throughout the world. The present edition (the 12th) is another in the line of magnificent revisions of the classic text originally prepared by J. Whitridge Williams and which he subsequently edited throughout the first five revisions. Henricus J. Stander continued the notable series by preparing the seventh, eighth and ninth editions, and Nicholson J. Eastman prepared the tenth and eleventh editions. The name of Dr. Hellman is, thus, added in 1961 to the listing of distinguished editors. The book comprises 1,205 pages with 666 illustrations and is quite comparable in length with the tenth and eleventh editions.

Five years have elapsed since the publication of the prior edition, and many important advances have been made in the science and art of obstetrics in this interval. The present edition adequately treats the acquisition of new knowledge in the fields of fetal physiology and its aberrations. Entirely new sections regarding fetal malformations, hemolytic disease of the newborn, placental transfer and asphyxia neonatorum have been added.

Extensive revisions are included concerning the subjects of the incompetent cervix, the cesarean section scar and its management, bacterial shock, hydramnios, uterine inertia, the vacuum extractor, sterilization and contraception. Important and major changes have been made in the sections dealing with the endocrines, anesthesia and pregnancy toxemia. The authors acknowledge assistance from Drs. Joseph Velardo, Hilton Salhanick, Georgianna Seegar Jones and J. Edward Hall in the field of endocrine information. The chapter on Toxemias of Pregnancy continues to be an outstanding section, as it has always been, with great emphasis on the enormous research work which has been produced in this field.

The chapter on multiple pregnancy has again been extensively revised by Dr. Alan F. Guttmacher.

The practice of including extensive bibliographies continues; it is, of course, of enormous help to the obstetrician confronted with a difficult problem and to authors who are preparing their own bibliographies.

In the section on postpartum hemorrhage, no mention is made of the recently emphasized entity of non-involution of the placental site.

In reference to the complication of carcinoma of the breast in the presence of pregnancy, the authors conclude that the consensus now does not favor interruption of the pregnancy in this situation.

The illustrations are characterized by the usual clarity associated with this treatise. One wishes that the publisher might have considered the newer format, utilized in many other basic textbooks, of two-column printing which somehow does seem to make for easier reading.

(continued on page 574)

Cook County Graduate School of Medicine Continuing Education Courses STARTING DATES-SPRING, 1962

Surgical Technic, Two Weeks, April 2, June 4
Surgery of Colon & Rectum, One Week, March 5, June 4
Advances in Surgery, One Week, March 19
Plastic Surgery of Head and Neck, One Week, April 9
Basic Principles in General Surgery, Two Weeks, April 23
General Surgery, One Week, May 7; Two Weeks,
April 2

Gynecology, Office & Operative, Two Weeks, April 9 Vaginal Approach to Pelvic Surgery, One Week, March 26

Obstetrics, General & Surgical, Two Weeks, March 12 Pain Relief in Childbirth, 3 Days, March 7 Proctoscopy & Sigmoidoscopy, One Week, March 26 Treatment of Varicose Veins, One Week, March 26 Basic Internal Medicine, Two Weeks, March 26 General Practice Review, One Week, May 21 Basic Electrocardiography, One Week, March 19 Gallbladder Surgery 3 Days, March 12 Surgery of Hernia, 3 Days, March 15 Urology, Two Weeks, April 2 Surgery of the Hand, One Week, April 16

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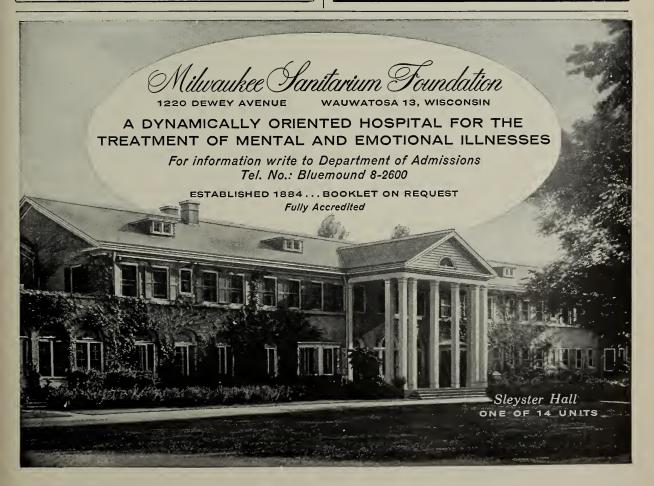
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Vio-Dex Timelets offer sustained release of dextroamphetamine. One Timelet in the morning lasts all day. Available in 10 mg. and 15 mg. dosage forms.

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Dextro- Amphetamine Phosphate Phenobarbital Mephobarbital Dextrose (9.4 ca	5.0 mg. 16 mg.	10 mg.*, 15 mg.** 32 mg.	2.5 mg. 8.0 mg. 2.5 mg.
Vitamin A Vitamin B-1 Vitamin B-2 Vitamin B-6 Vitamin C Vitamin E	100 1.U. 1200 1.U. 3 mg. 3 mg. 1 mg. 100 mg.	5000 f.U. 1200 I.U. 3 mg. 3 mg. 1 mg. 100 mg.	1000 I.U. 100 I.U. 0.5 mg. 0.5 mg. 0.15 mg. 15 mg.
Niacinamide Calcium Pantothenate	20 mg. 2 mg.	20 mg. 2 mg.	3 mg. 0.3 mg.
*Orange, coated †1 before each n			blets ††1 a day r between meals

For more facts, see your local Rowell man or write:



BOOK REVIEWS (continued from page 572)

In summary, the twelfth edition of Williams Obstetrics under the combined editorship of Drs. Eastman and Hellman is a modern monument to obstetric knowledge and provides a magnificent review of theory and practice for all who render care to pregnant women.

Thomas W. McElin, M.D.

CARCINOMA OF THE CERVIX. John B. Graham, M.D., Luciano S.J. Sotto, M.D., and Frank P. Paloucek, M.D. \$14. Pp. 498. Philadelphia, W. B. Saunders Company, 1962.

The authors have accomplished a selective collection of accumulated information from the past on carcinoma of the cervix and have tempered it by personal experience. The value of the book is enhanced because the senior author has been associated with men preeminent in all phases of cervical cancer. The book proposes a desirable trend by portraying the individual who seriously considers treating this lesion as an expert gynecologist, radiologist, and radiophysicist as related to cervical cancer. The Table of Contents is complete, and the book is thoroughly indexed. There is an ample number of tables to aid in the interpretation of necessary statistical data, and the illustrations are excellent.

A minor difference of opinion is present in the case of a patient with cervical carcinoma in the third trimester of pregnancy, with a viable fetus, who was treated by primary radium application followed in two to three weeks by cesarean section. A primary classical cesarean section followed by radiation therapy is also an effective mode of therapy. The statement that cervical cancer tends to be more malignant during pregnancy is disputable. The chapter on radiation physics is welcome and stresses that dosage of radium as expressed in milligram hours could be more effectively presented as gamma roentgens or rads at some point or plane in the pelvis with the distribution of the radium and radiation taken into account.

The book is very well written and is an outstanding contribution to oncology. It is recommended to all physicians who encounter cervical cancer.

Larry McGowan, M.D.

NEWS of the STATE



Adams County

Medical Society Honors Students

The annual joint luncheon meeting of the Adams County Medical Society and the Quincy Kiwanis Club will take place Monday, May 21, in the ballroom of the Lincoln Douglas Hotel, Quincy. The 58 academically top seniors from the seven county high schools and their respective school principals and counselors will be the honor guests of the society and its Swanberg Medical Foundation.

The students became Award Members of the Society for Academic Achievement in April; the principal sponsors of the SAA programs nationally are the Kiwanis Club and the Medical Foundation.

Cook County

M.D.'s in the News

Dr. Konstantin Dimitri, Galesburg, has been appointed superintendent of East Moline State Hospital, assuming the position made vacant by the death of Dr. Martin S. Sloane. Dr. Dimitri had been staff physician and clinical director at Galesburg State Research Hospital since 1960. . . . The University of Chicago has named Dr. Humberto Fernandez-Moran as professor of biophysics, effective July 1. Since coming to the United States in 1958 he has been a research associate in neuropathology at Harvard University, visiting lecturer in the department of biology at MIT and associate biophysicist at Massachusetts General Hospital.... Dr. Robert L. Schmitz, Chicago, is the new president of the Mercy Hospital medical staff. Dr. Schmitz, also an associate clinical professor at Loyola University's Stritch School of Medicine, succeeds Dr. George F. O'Brien. Other new officers are *Dr. John M. Coleman*, vice president, and *Dr. Walter F. Dillon*, secretary-treasurer, both of Chicago.

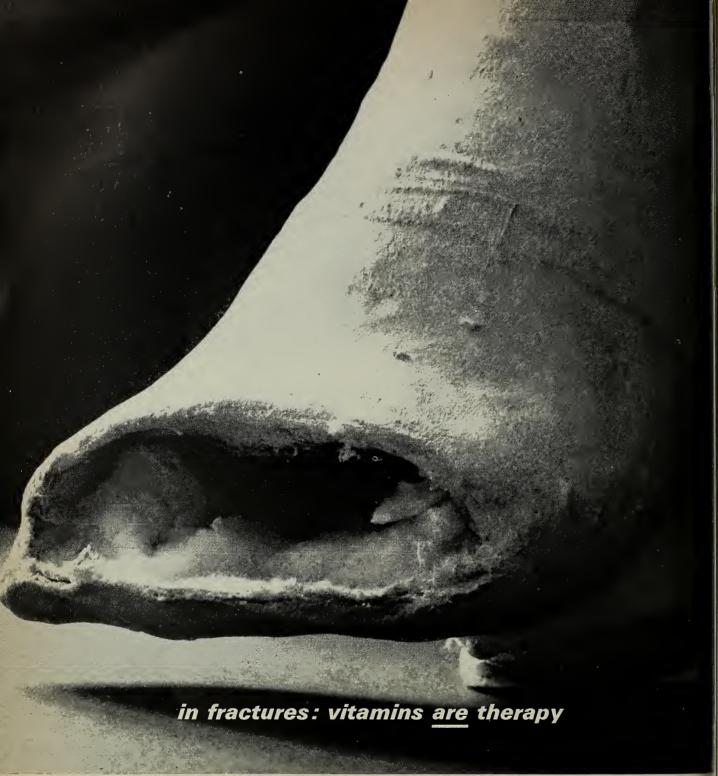
In March Chicago's Medal of Honor for Distinguished Service to the Community was presented to Dr. E. Lee Strohl by Mayor Daley. Dr. Strohl is president of the Board of Directors of Chicago's Municipal Tuberculosis Sanitarium, and senior attending surgeon at Presbyterian-St. Luke's Hospital. . . . Dr. Wallace W. Kirkland, Jr., associate attending physician at Presbyterian-St. Luke's Hospital, has been elected president of the Alumni Foundation. Other officers include Drs. Arthur L. Ratko, vice president, Richard E. Buenger, secretary, and Robert E. Slayton, treasurer. . . . The 1962 officers of the Chicago Psychoanalytic Society are Drs. Frances Hannett, president; Heinz Kohut, president elect; Anne Benjamin, secretary, and James Alexander, treasurer, all of Chicago.

Dr. Kate H. Kohn has become Director of Medical Services at Rest Haven Rehabilitation Hospital, Chicago. Dr. Aaron M. Rosenthal, recently of the University of Pennsylvania Hospital, has also been appointed Medical Director there. . . . Dr. Malcolm M. Stanley, professor of medicine at the University of Louisville since 1958, has accepted a similar position with the University of Illinois College of Medicine, effective July 1. Effective immediately at the College of Medicine was the appointment of Dr. Alberto de la Torre as clinical assistant professor of psychiatry.

Forest Hospital Addition Opens

A new half-million dollar addition to Forest Hospital, Des Plaines, will open June 1, advancing the hospital's pilot program of milieu therapy for mentally ill patients.

The new structure adjoining the present (Continued on page 582)



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B ₁ (Thiamine Mononitrate)	10 m
Vitamin B ₂ (Riboflavin)	10 m
Niacinamide	100 m
Vitamin C (Ascorbic Acid)	300 m)
Vitamin B ₆ (Pyridoxine HCI)	2 m.
Vitamin B ₁₂ Crystalline	4 mcgl-
Calcium Pantothenate	20 m

Recommended intake: Adults, 1 capsule day or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



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Number 31

Normal Laboratory Values of Clinical Importance - Part 1.

BLOOD—Chemical Constituents

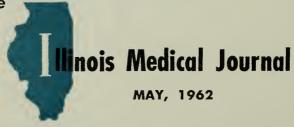
Albumin, serum	.4.0-5.2 Gm./100 ml.
Ammonia, serum	.0.15-0.3 mg./100 ml.
Amylase, serum (Myers and Killian)	.less than 50 units/100 ml.
Ascorbic acid, serum	.0.4-1.0 mg./100 ml.
Ascorbic acid, white cells	.25-40 mg./100 ml.
Base, total, serum	.145-155 mEq./L.
Bilirubin, total, serum	.0.1-0.8 mg./100 ml.
Direct	.0.1-0.2 mg./100 ml.
Indirect	.0.1-0.6 mg./100 ml.
Calcium, serum	.9-11 mg./100 ml.; 4.5-5.5 mEq./L.
Carbon dioxide-combining power, serum	.50-65 volumes %; 21-28 mEq./L.
Carbon dioxide content, serum	.50-70 volumes %; 21-30 mEq./L.
Carbon dioxide tension, serum	.38-40 mm. Hg
Carotenoids, serum	.100-200 µg./100 ml.
Chlorides, serum (as Cl)	. 100-106 mEq./L.; 355-376 mg./100 ml
Chlorides, serum (as NaCl)	.585-620 mg./100 ml.
Cholesterol, total, serum (Schoenheimer-Sperry method)	.160-270 mg./100 ml.
Cholesterol as esters, serum	
Cholesterol ester fraction of total cholesterol, serum	. 60-75%
Copper, serum	.90-120 μg./100 ml.
Corticoids, plasma (Porter-Silber)	
Creatinine, serum	-
Fat, neutral, serum	
Fatty acids, serum	
Fibrinogen, plasma	
Globulins, serum	
Glucose (fasting), blood	
Glutamic oxaloacetic transaminase, serum	
Hemoglobin, blood, males	
females	
Icterus index, serum	
Iodine, protein-bound, serum	
Iron, serum	.
Iron binding capacity, serum	
Lipase, serum	
Lipids, total, serum	
Magnesium, serum	
Nitrogen, nonprotein, serum	
Oxygen capacity, blood	
Oxygen content, arterial blood	
Oxygen content, venous blood, grm	
Oxygen per cent saturation, arterial blood	
Oxygen per cent saturation, venous blood, arm	
Oxygen tension, serum	
ρH serum	
Phosphatase, acid, serum (Guiman or King-Armstrong method)	
(Bodansky method)	
Phosphatase, alkaline, serum (Bodansky method)	
(King-Armstrong method)	
Phospholipids, serum	
Phosphorus, inorganic, serum	
Potassium, serum	
Proteins, total, serum	-

Proteins, total plasma, electr	
Albumin	58%
α-Globulins	14%
β -Globulins	13%
γ-Globulins	11%
Fibrinogen	4%
*Prothrombin, plasma (Quick	method)14-18 seconds, by control plasma
Sodium, serum	137-143 mEq./L.
Urea nitrogen, serum	10-20 mg./100 ml.
	3.0-6.0 mg./100 ml.
	50-100 µg./100 ml.
Hematologic Exan	
Bleeding time	1-5 minutes
Cells, differential count:	
Lymphocytes	1250-3500 per cu. mm25-35%
Monocytes	200-1000 per cu. mm4-10%
Neutrophils	
Young (nonfilament)	150-1500 per cu. mm3-15%
Adult (filament)	2500-6500 per cu. mm50-65%
Eosinophils	25-400 per cu. mm
Basophils	0-200 per cu. mm0-2%
Erythrocytes	per cu. mm
Leukocytes	per cu. mm5-10 thousand
Platelets	per cu. mm
Reticulocytes	per cu. mm
	ood (Lee-White method)4-12 minutes
	cells (MCV), mean
	red cells (MCH), mean
	centration of red cells (MCHC), mean27-32 gm./100 ml. of packed red cells
	ge
	maximal resistance
	minimal resistance
	i cells)
	14-17 Gm./100 ml.
	with age
	or, saturation, volume0.9-1.1
Sedimentation rate: Cutler,	men2-8
	women2-10
Rourke	and Ernstene not more than 0.4 mm. per min.
Westerg	renless than 15 mm. in 1 hour
Wintrob	e, men0-9 mm. in 1 hour
	women0-20 mm. in 1 hour
Volume, bloodpo	er sq. meter body surface 2800-3800 ml.; per kg. body weight 70-100 ml.
*Quick's one-stage prothromb Reprinted by permission from	oin time, allowable range 11 - 121_2 sec. Current Therapy—1961. Edited by Howard F. Conn, M.D., W. B. Saunders Company.

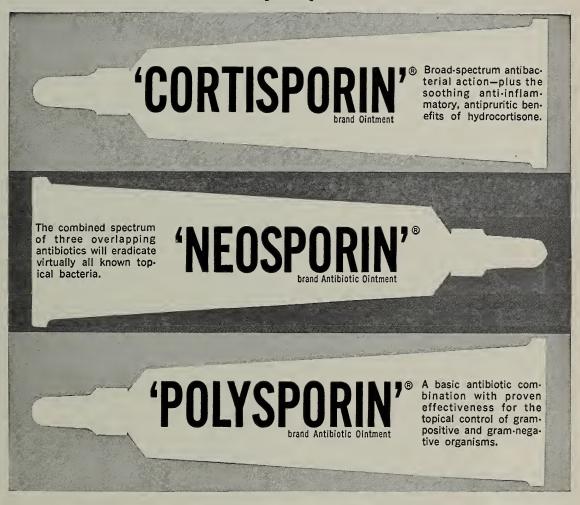
Part II—June 1962 Issue—Functional Tests

Part III-July 1962 Issue-Bone Marrow, Urine, Stool and Cerebrospinal Fluid





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Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	_	5 mg.	5 mg.
Hydrocortisone	-	-	10 mg.
Supplied:	Tubes of 1 oz., $\frac{1}{2}$ oz. and $\frac{1}{8}$ oz. (with ophthalmic tip)	Tubes of 1 oz., $\frac{1}{2}$ oz. and $\frac{1}{8}$ oz. (with ophthalmic tip)	Tubes of ½ oz. and ½ oz. (with ophthalmic tip)



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

STATE News (Continued from page 577)

facility will offer an indoor swimming pool and gymnasium, an open area for selected patients, game and music rooms, and an outdoor tennis and squash court.

Also provided are a workshop, two day rooms, a beauty and barber shop, kitchen, dining room and cafeteria, along with offices and lounges for doctors and administrative and bookkeeping departments. The building will not increase the hospital's present 90-bed capacity.

Resident Program Instituted

The Little Company of Mary Hospital, Evergreen Park, has acquired approval for a three-year training program for surgical residents, beginning July 1.

Kane County

Old-time Society Rally

The Kane County Medical Society, assisted by the Illinois Medical Political Action Committee, hosted an old-fashioned medical-political dinner and rally March 21. Two hundred fifty physicians, pharmacists, wives and guests heard seven-minute talks by six of the ten candidates for Congress from the 15th District; all ten had received invitations.

Dr. William J. Ball, society president, presided; Dr. John A. Newkirk, chairman of IMPAC, was in charge of the program. The candidates present were Edmond B. Thornton, Ottawa, William H. Edwards, Jr., Sycamore, James W. Terry, Sandwich; and Robert F. Casey, Dr. M. R. Saxon, and Frank R. Reid, all of Aurora.

The old-time rally atmosphere was punctuated by banners, posters identifying the candidates, and by rousing music played by musicians dressed in Revolutionary War costumes.

McLean County

New Medical Society Director

The McLean County Medical Society has appointed a paid executive director, David W. Meister of Peoria, to head the administrative work of the organization. Mr. Meister is also executive director of the medical societies of Peoria and Tazewell counties. In 1961 he was voted "Medicine's Man of the Year" by Tazewell County for his work with the society.

Montgomery

Dr. William A. Tibbs, Jr., instructor of internal medicine, Washington University School of Medicine, was the speaker at the April meeting of the county medical society. His topic was "Diagnosis and the More Recent Treatment of Some of the Pulmonary Diseases as Fibrosis, Emphysema, etc."

Warren County

New 50-Year Club Members Inducted

Dr. Charles P. Blair and Dr. Frank C. Winters of Monmouth were the honored guests at a dinner March 21 where they officially joined the 50-Year Club of the Illinois State Medical Society. The presentation of pins and certificates was made by Dr. Fred C. Endres of Peoria, councilor from the Fourth District.

Dr. James H. Hutton, Chicago, delivered the principal address before about 185 friends, patients, local physicians and physicians throughout the state who gathered to pay tribute. Dr. John L. Hoyt of Roseville, president of the Warren County Medical Society, presided.

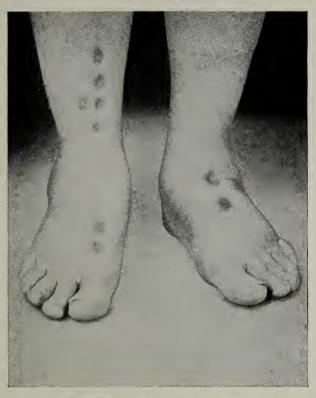
Dr. Blair was the councilor from the Fourth District for 12 years before he was succeeded by Dr. Endres, and was chairman of the Council for two years. He also chaired the Education Committee.

General

High Accidental Poisoning Rates

Poisonings cause more deaths each year in children under age five than the combined effects of measles, polio, diphtheria, typhoid and scarlet fever in the same age group, according to the National Office of Vital Statistics. Recent figures from the Illinois Department of Public Health noting 15,000 annual cases of accidental poisoning in children in Illinois bear this out.

About 8,000 cases are now being reported (Continued on page 584)



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annually by the 76 poison control centers in the state and the approximately 80 other hospitals which are not official centers. Estimates based on the reporting hospitals add 7,000 to 8,000 cases treated annually in other Illinois hospitals (there are 300 in the state). These totals do not include cases treated in physicians' offices or at home by first aid.

Illinois was one of the first states to enact a Uniform Hazardous Substances Labeling Act to aid in preventing accidental poisonings, but the life and health of about 40 Illinois children are still at stake each day because of carelessness in the home.

New Housing for Mentally Retarded

Drake Cottage, a 100-bed unit for the totally dependent (non-ambulant) mentally retarded, opened in April at Lincoln State School. Fifty patients from six to 20 years old from each of the waiting lists at Lincoln and Dixon State schools were admitted. Some had been on the lists eight years.

The building is a remodeled one formerly

used for tuberculosis patients at Lincoln. Because of the reduction in TB cases over the past few years it was possible to move the entire TB program for the mentally retarded to Dixon, leaving space at Lincoln for the new facilities.

There remain about 90 persons on the waiting lists who could not be accommodated.

Doctors Placed by Society Service

This past month three physicians entered practices in widely divergent areas of the state with the assistance of the Physicians' Placement Service. Their letters amply demonstrate their gratitude:

William E. Erkonen, M.D., who selected Princeton in Bureau County, wrote "Thank you for a superior service for the new doctor."

Paul W. Clark, M.D., told the service, "Directly due to your help I have decided on Rockton" (Winnebago County). And Charles P. Salisbury, M.D., who became the fourth physician in Albion, Edwards County, expressed his "thanks for your cooperation and interest."



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The Placement Service has long served an important function in the Society's framework, aiding hundreds of physicians in finding suitable locations throughout the entire state since its inception at the end of World War II.

Deaths

G. Henry Mundt, noted pioneer in ophthalmology and long in the forefront of medical society affairs, died April 2 at the age of 76. In his 50 years as a Chicago physician Dr. Mundt compiled an impressive record as a leader in his profession. He was president of the Illinois State Medical Society in 1927-28 and had the distinction of the longest tenure of any delegate to the American Medical Association's House of Delegates—33 years. He also served several terms as a delegate to the state society's House of Delegates.

In 1911 he received his M.D. degree from the University of Illinois College of Medicine and later did graduate work in Vienna, Berlin and London. He was certified by the American Board of Otolaryngology in 1925 and by the American Board of Ophthalmology in 1930.

Dr. Mundt devoted many extra hours to his specialty and to Chicago medicine. He was a past president of both the Chicago Ophthalmologic and Chicago Laryngological and Otological societies. At the time of his death he was a counselor of the Chicago Medical Society. He was president of the Chicago Medical School from 1932 to 1935. In addition, he was an emeritus member of the staffs of Evangelical and Christ Community hospitals.

Dr. Mundt belonged to the Normal Park Masonic Lodge, the Scottish Rite Bodies of

Chicago and Medinah Shrine Temple.

He leaves his widow, Mrs. Grace W. Mundt; a son, G. Henry Mundt, Jr., M.D., an ophthalmologist who was associated with his father, and a daughter, Mrs. Joyce MacLean of Wilmette.

Jacob L. Albright*, retired, Chicago, a graduate of the University of Illinois College of Medicine in 1902, died March 1, aged 90. Formerly a staff member of Evangelical Hospital, he retired in 1953 after more than 50 years of Chicago practice. He was an emeritus member of the Illinois State Medical Society, also belonging to its 50-Year Club.

Hayden E. Barnard*, Hinsdale, a graduate of Rush Medical College in 1919, died March 28, aged 65. He was on the consulting staff at Community Memorial Hospital in La Grange. A former head of the surgical anatomy department at Northwestern University Medical School, he had been senior attending surgeon at Wesley Memorial Hospital from 1925-35, also holding the posts of secretary, vice-chief and acting chief of staff there at various times.

Salamon Boros*, retired, Chicago, a graduate of Jenner Medical College in 1912, died March 7, aged 75. A past president of the Edgewater Hospital medical staff and an emeritus member of the ISMS, he practiced in Chicago 50 years before his 1961 retirement.

Mercer T. Brown*, Zion, a graduate of Northwestern University Medical School in 1926, died March 8, aged 60. He had practiced in Zion since 1927 and was a staff member at St. Therese's and Victory Memorial hospitals in Waukegan and Zion Community Hospital. He also served at Lake County General

(Continued on page 589)



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Hospital until 1960 and was a past president of the Lake County Medical Society. In World War II he was with the U.S. Army Medical Corps, heading a training program at Camp Davis, S. C., and later a hospital in the Philippines.

Vincent J. Gaul*, River Forest, a graduate of Loyola University School of Medicine in 1936, died March 13, aged 52. A staff physician at Oak Park Hospital since 1943, he also was a member of the executive committee and a former president at the hospital. His memberships included the American Academy of General Practitioners, the International College of Surgeons and the American Geriatrics Society.

Michael Goldenburg*, Chicago, a graduate of Dearborn Medical College in 1905, died March 11, aged 82. In practice for 50 years, he belonged to the Illinois State Medical Society's 50-Year Club and had emeritus membership. He was senior eye surgeon at the Illinois Eye and Ear Infirmary, a past president of the Chicago Ophthalmological Society and vice president emeritus of the Columbus Hospital staff.

Charles F. Greene*, retired, Chicago, a graduate of the Hahnemann Medical College and Hospital in 1913, died March 26, aged 71. Prior to retiring four years ago he was head of obstetrics at Jackson Park Hospital.

William M. Hanrahan*, Chicago, a graduate of Loyola University School of Medicine in 1922, died February 26, aged 64. He did graduate studies in Vienna, Budapest and Dublin and was a fellow of the American College of Surgeons and secretary-treasurer of the Suburban Cook County Maternal and Infant Welfare Committee. At one time he was chief of staff at Lewis Memorial Maternity Hospital and was a former chief of the division of maternal and child health of the Cook County Department of Public Health.

Winston I. Breslin*, Chicago, a graduate of the University of Toronto Faculty of Medicine in 1938, died March 12, aged 47. He was an attending psychiatrist at Michael Reese Hospital and was certified in psychiatry and neurology in 1945. A major in the Royal Canadian Army Medical Corps in World War II, he belonged to the American Psychoanalytic and the American Psychiatric associations.

Walter E. Kittler*, Rochelle, a graduate of the University of Illinois College of Medicine in 1902, died February 22, aged 84. He practiced more than 50 years in Rochelle and was a onetime member of the city council. He was a delegate to the American Medical Association for ten consecutive years and a delegate to the Illinois State Medical Society for 30 years. Dr. Kittler was a past president of the Ogle County Medical Society and a railroad physician in Rochelle 30 years. In World Wars I and II and the Korean conflict he served as a draft board examiner. He was an emeritus member of the ISMS and also belonged to the 50-Year Club.

Arthur E. Mahle*, Evanston, a graduate of Washington University School of Medicine, St. Louis, in 1918, died March 27, aged 68. From 1956-58 he was chief of the medical staff at Wesley Memorial Hospital. He also was associate professor of medicine at Northwestern University Medical School, medical director of the Methodist Old Peoples Home and a diplomat of the American Medical Board of Internal Medicine. He was a fellow of the American College of Physicians and received his certification in internal medicine in 1937.

David E. Markson*, Chicago, a graduate of Northwestern University Medical School in 1912, died March 6, aged 71. He was a staff member at Wesley Memorial Hospital for 21 years, an associate professor of medicine emeritus and a consultant at the Arthritis Clinic at Northwestern University Medical School, and on the courtesy staff at Passavant Memorial Hospital. He had membership in the American Rheumatism Association, was a fellow in the American College of Physicians, and in 1937 was certified in internal medicine.

Ira B. Robertson*, Chicago, a graduate of Bennett Medical College in 1915, died March 6, aged 73. He practiced on the west side 45 years and served as medical superintendent for the old Jefferson Park Hospital for 25 years; he had emeritus membership in the Illinois State Medical Society and was an emeritus staff member at Walther Memorial Hospital.

Frederick W. Rohr*, Chicago, a graduate of Rush Medical College in 1914, died March 1, aged 73. He was director of the medical department of Sears, Roebuck & Company for

for May, 1962 589



Team

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Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differen-

tiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped. Deaths (Continued from page 589)

55 years and was on the obstetrical staff of Ravenswood Hospital. He belonged to the American College of Surgeons and was an emeritus member of the ISMS.

John G. Slaney, Danville, a graduate of Marquette University School of Medicine in 1926, died February 16, aged 60. Chief surgeon at the Veteran's Administration Hospital, Danville, Dr. Slaney served in the U.S. Army Medical Corps in World War II.

Martin S. Sloane*, East Moline, a graduate of Hamburg University Faculty of Medicine, Germany, in 1924, died March 20, aged 62. In 1942 he came to the United States after 14 years of private practice in Hamburg and in 1946 joined the staff of Kankakee State Hospital, serving as assistant superintendent there from 1951-52. He was assistant superintendent at Anna State Hospital from 1953 until 1957, when he came to East Moline State Hospital as superintendent. Dr. Sloane also was a visiting professor at Augustana College, chairman of the board of the Rock Island Council on Alcoholism and a board member of the Rock Island County Mental Health Society.

He belonged to the Public Health Association, the Academy for Advancement of Science, the American Academy of Political and Social Science and was a fellow of the American Psychiatric Association.

Sydney W. Tauber*, Chicago, a graduate of the University of Illinois College of Medicine in 1939, died March 28, aged 48. A founder and medical director of the Westown Medical Center, he served as a U.S. Air Corps flight surgeon during World War II.

James S. Templeton*, retired, Pinckneyville, a graduate of St. Louis College of Physicians and Surgeons in 1898, died March 4, aged 90. In 1941-42 he had a term as president of the Illinois State Medical Society and in 1948 was named to its 50-Year Club. He was named Illinois Doctor of the Year in 1952; he also appeared on "This Is Your Life" that year. He was a former mayor (1913) of Pinckneyville, a former director and president of the town's First National Bank, and a charter member and past president of the Rotary Club there. He had been the prison physician at the Illinois

^{*}TRADEMARK, REG. U.S. PAT. OFF. © 1962, THE UPJOHN COMPANY DECEMBER, 1961

Penitentiary at Menard and surgeon for the Missouri-Pacific and Illinois Central railroads.

Harris J. Timerman*, Oglesby, a graduate of Northwestern University Medical School in 1934, died February 27, aged 53. He received certification in obstetrics and gynecology in 1941 and served on the staffs at Wesley Memorial, Presbyterian-St. Luke's, Swedish Covenant, St. Mary's and People's hospitals. He also instructed in the obstetrics department at Northwestern University Medical School and was an associate in obstetrics at the Chicago Maternity Center.

Wesley Van Duine*, Chicago, a graduate of the Hahnemann Medical College and Hospital in 1918, died February 24, aged 67. He was a staff member at Swedish Covenant, Ravenswood and Edgewater hospitals.

James B. Waddell*, Elmhurst, a graduate of the General Medical College in 1924, died March 10, aged 65. He was a past president of the Maywood Rotary Club.

Stephen L. West*, Springfield, a graduate of Johann Wolfgang Goethe University, Frank-

furt-on-Main, Germany, in 1927, died March 27, aged 60. In 1942-43 he was chief of the eye, ear, nose and throat service at the VA Hospital in Marion. From 1949-50 he was on the staff at St. John's and Memorial hospitals in Springfield, and in 1950 was certified in otolaryngology. During World War II he was in the U.S. Army Medical Corps; he had membership in the Pan American Association of Ophthalmologists and a fellowship in the American Academy of Ophthalmology and Otolaryngology.

Edwin G. C. Williams*, Fort Myers, Fla., a graduate of the University of Michigan Medical School in 1910, died March 25, aged 75. He did cancer research at the Cancer Hospital, London, Eng., in 1928. His affiliations were with the International Commission for Radiological Standards, the American College of Radiology, the Cancer Research Society of London, the Radium Institute of Stockholm, Sweden, and the 50-Year Club of the ISMS.

*Indicates member of Illinois State Medical Society.

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*Ayd, Frank J., Jr.: Drug-induced Extrapyramidal Reactions: Their Clinical Manifestations and Treatment with Akineton. Psychosomatics 1:143 (May-June) 1960.



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By ROBERT L. RICHARDS Executive Administrator

John W. Neal Appointed CMS Executive Administrator



John W. Neal

As a representative of the Illinois State Medical Society and as a personal friend, I wish to extend heartiest eongratulations and good wishes to Jack Neal on his appointment as Executive Administrator of the Chicago Medical Society. I have had the pleasure of professional association with Jack for more than two years, during which time he has proven his top administrative qualifications on innumerable occasions. CMS could not have selected a more capable, experienced, and dedicated leader.

Jack's experience in medical organization spans 21 years. An original "downstater" transplanted to Chicago, he is personally acquainted with hundreds of Illinois physicians. As legal counsel for ISMS since 1941 and CMS since 1953, he is intimately familiar with the problems of both large and small medical societies. These qualifications make him ideally suited to provide continuing, effective liaison between ISMS and CMS.

The long record of medical service compiled by Jack includes membership in the Executive Committee of the Illinois Society for Medical Research; the Medical-Legal Committee of the Institute of Medicine of Chicago; and the Home Care Committee of the Chicago Heart Association. He is an Ex-Officio member of numerous ISMS committees, and has worked with both ISMS and CMS officials in drafting the original state law under which the Illinois Blue Shield Plan operates.

For the past 12 years, Jack has served as registrar of the Cook County Graduate School of Medicine, a continuing medical education center affiliated with Cook County Hospital. A graduate of the Northwestern University School of Law, he was admitted to the Illinois Bar in 1938. He is a member of the Chicago, Illinois State and American Bar Associations.

Service to medicine in Illinois is a tradition in the Neal family. Jack's father, the late Dr. John Ross Neal, was a past president of the Illinois State Medical Society. He praeticed in Springfield, Illinois, and was a pioneer in establishing the pattern of legislative understanding that remains the foundation of the good relations existing today between today's medical profession and the Illinois legislature. Jack's mother, Mrs. John R. Neal, of Glenview, Illinois, and Washington, D. C., is a past president of the Woman's Auxiliary of the Illinois State Medical Society.

Jack, his wife Loretta, and their four children reside in Glenview, Illinois.

The ILLINOIS Medical Journal

Official Journal of the Illinois State

M

Medical Society

June, 1962

The Surgical Treatment of Diabetic Vascular Disease

GEZA DE TAKATS, M.D., M.S., F.A.C.S., Chicago

THE SURGEON HAS ALWAYS reflected the current trends of thought on diabetes in his activities. He is asked to amputate diabetic toes or limbs, incise abscesses under the plantar fascia and occasionally operate on a pseudocyst of the pancreas following acute pancreatitis. He has been told by pathologists and internists that diabetic vascular disease is atherosclerosis, except that it is accelerated just as in gout or hypertension. Empirically, he has known for a long time that the diabetic foot is different from the arteriosclerotic one. This article outlines these differences, examines the possible mechanisms which are responsible for them and describes the management of the various forms of neurovascular disease in the diabetic.

The Vascular Lesion

Volume 121, No. 6

Diabetics frequently show major arterial occlusions, predominantly in the lower extremities. The atheromatous lesion on inspection (Fig. 1), on microscopic section and in the

From the Presbyterian-St. Luke's Hospital, Chicago, Ill.

Presented at the Annual Meeting of the Chicago Diabetes Association, November 10, 1961.

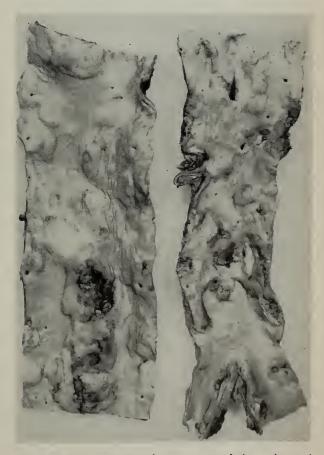


FIGURE 1. Huge, fatty plaques, some of them ulcerated in the abdominal aorta of a 50 year old diabetic woman, who died of a myocardial infarct. Note the concentric diminution of the ostia of the lumbar arteries at the left and right margins of the specimen on the left. They nourish the spinal ganglia and the cord.





FIGURE 2. Femoral arteriogram of a 45-year-old diabetic male presenting intermittent claudication. The superficial femoral artery is narrow and then closed at midthigh. The profunda is enlarged, shows abundant collaterals and anastomoses just below a calcified plaque at the lower end of the superficial femoral. This is the ideal femoral by-pass provided by nature.

FIGURE 3. Typical concentric medial calcification in the femoral artery of a non-diabetic, whose arteriogram showed good patency and smooth contours of the vessel.

angiogram (Fig. 2), shows no difference from non-diabetic atherosclerosis. Calcification of major vessels occurs and is not of the Möncheberg type (Fig. 3). The author can not recall seeing clear-cut medial sclerosis causing a non-pulsatile but patent artery in a diabetic.

In addition to major arterial disease, or often in the absence of it, there develops a terminal vascular lesion in arterioles, capillaries and venules. Recent studies with PAS stains and with the electron microscope would indicate that this lesion consists of a subintimal proliferation of acid-mucopolysaccharides and that the lesions in the retina and kidney of the diabetic are identical with those seen in the terminal vascular bed of the extremities.² Of course, this is a most appealing concept to the surgeon, whose limb or digit-saving activities are so acutely hampered by arteriolar disease.

Clinically, the sudden development of a black patch on the big toe, on the heel and on other pressure points has been recognized by surgeons for years as due to a subcutaneous hemorrhage from fragile, aneurysmatous venules, as occur in the retina. Capillary fragility is often demonstrable in diabetes by a tourniquet test. This, then, is not the equivalent of a gangrenous toe of the arteriosclerotic, whose vascular occlusion

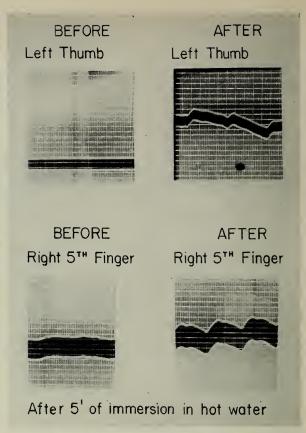


FIGURE 4. Digital plethysmograms in the case of P.D.L. In a cool room (65°F.) the pulsations were not transmitted. After immersion into hot water for five minutes, pulsations were better in the right fifth finger than in the left thumb. There were mild Raynaud's phenomena present.

is in the major vessels. Dible³ has repeatedly emphasized the point that even in the presence of gangrene, the arteries of the foot, namely the plantar and the digital vessels, are relatively unaffected, and that injected specimens are capable of demonstrating a delicate terminal network in the presence of a proximal arterial occlusion. Gangrene with intact, or often with patulous terminal vessels, is due to stagnation, anoxia, exudation of plasma and increase in blood viscosity with ultimate sludge, but not to vascular disease.

Since the diabetic has both a proximal atherosclerotic disease and a distal diabetic angiopathy,⁴ any injury is poorly tolerated. For this reason, examination of the state of the terminal vessels also is of great interest. This is best examined by the histamine-flare. The presence of an adequate flare not only means that the cutaneous vessels are capable of dilatation, but that the sensory nerve supply is intact, so that the axon reflexes in the skin are operating.⁵





FIGURE 5. Painless, perforating ulcer leading to a neuro-trophic joint. This will heal when the metatarsal head is excised. This should have been done at the time of toe-amputation.

FIGURE 6. Callus, hyperkeratosis, large, deformed feet with recurrent attacks of acute lymphangitis. Good chiropody and daily washings with hexachlorophene (Phiso-Hex) were all that was necessary.

Other methods, such as digital plethysmograms following application of direct heat, reflex heat or nerve block, will readily demonstrate that the terminal circulation of the diabetic is often impaired. The digital vessels of one patient while exhibiting mild Raynaud's phenomena, were incapable of full vasodilation especially in the left thumb and less in the right fifth finger (Fig. 4).

The accumulation of acid-mucopolysaccharides in the wall of diabetic terminal vessels makes one wonder whether or not their anticoagulant or fibrinolytic activity is responsible for the tendency to hemorrhage. A study of conjunctival vessels with the slit-lamp has revealed stasis and sludging of conjunctival vessels.⁶

Neuropathy

Diabetic neuropathy plays an important role in the clinical appearance and behavior of the diabetic extremity. First, there is a phase of acute neuritis with hyperhidrosis and dysesthesia, with moderate vascular changes usually of the peripheral type. Objective neurologic findings are negative. There is another phase in which the deep tendon reflexes are absent with decrease of motor and sensory nerve conduction and vibratory sense; there is anhidrosis as a result of a sympathetic paralysis caused by the diabetic neuropathy and there are painless perforating ulcers leading to bone or joint (Fig. 5). Finally, there is the Charcot joint in the



FIGURE 7. Note the swollen, deformed right neurotrophic ankle. Foot was warm and oscillometric curves were increased.

foot or ankle producing great deformity, calluses and hyperkeratoses (Figs. 6 and 7).

Because the diabetic neuropathy often interrupts sensory conduction, the axon-reflexes are absent. This means that pressure on the heel, producing ischemia, will not be followed by reactive hyperemia. The histamine-flare measures this reflex very effectively. It is also capable of demonstrating the demyelinization of rapidly conducting nerve fibers, when the burning pain is not experienced in two to four seconds, but is delayed for 16 to 20 seconds.

Because of diminished sensory nerve supply, prodigious abscesses can accumulate under the plantar fascia. The resulting edema impedes the already impaired terminal vascular circulation; the plantar fascia becomes necrotic and needs wide removal.

Since the damage to peripheral nerves is patchy and limited to certain fibers, complete sensory loss is not observed. When the sympathetic fibers are intact and the heavy myelinated fibers selectively impaired, the inter-



FIGURE 8. Bilateral transmetatarsal amputations for a 34 year old severely diabetic male, who has had recurrent attacks of lymphangitis, multiple areas of gangrene, and spent several weeks in bed each year. With shoes padded in front with foam rubber, he walked with no difficulty.

mittent, hot, burning pain is experienced as in a causalgic state.⁷ There is cross stimulation between sympathetic and such demyelinated fibers, and sympathectomy gives great relief. When the sympathetics are destroyed resulting in a warm, dry and yet pulseless foot, sympathectomy is not indicated.

The lancinating pain which occurs in tabes and also the diabetic pseudotabes, is accompanied by vasodilation; the neurotrophic joint itself is warm and gives evidence of increased blood flow.⁸ There is, then, no point in doing sympathectomies for Charcot joints as sometimes advocated.

Clinical Syndromes and their Management

- 1. Cold, sweaty foot with diminished or absent pulsations at the ankle; no claudication at the calf, intermittent numbness and paresthesia and good temperature response to posterior tibial block. Here, lumbar sympathectomy and good foot hygiene are needed, as is selection of a good chiropodist for continued management.
 - 2. Warm, dry feet with calluses, hyperkera-





FIGURE 9. Severe, painless destruction of toe joints, spontaneous fractures and bone-proliferation (Charcot joints) in a 50 year old diabetic woman with no evidence of calcification of digital vessels.

FIGURE 10. Massive, wet gangrene with chills, high fever and coagulase positive staphylococcus septicemia in a 58 year old diabetic with poor foot hygiene, uncontrolled ringworm infection and massive arterial and venous thrombosis above the knee.

toses, recurrent fissures with superimposed lymphangitis; patchy loss of vibratory sense, decreased motor and sensory nerve conduction. Foot hygiene, padding of pressure points and arches, removal of toes if ulceration or gangrene supervene is indicated here (Fig. 7); also wide incision of plantar fascia abscesses.

- 3. Charcot joints in the ankle or foot joints, perforating ulcers, painless, warm, pulseless, deformed feet. Management here is excision of ulcers with resection of joint and corresponding digit, plus foot hygiene (Figs. 8 and 9).
- 4. Ulcerated, infected toe, plantar fascia abscess, lymphangitis, high fever. This requires removal of toe, wide incision and drainage of infected foot.
- 5. Gangrene of the heel with otherwise fair collateral circulation. Enzymatic debridement and split-thickness graft is the proper procedure here.



FIGURE 11. High metatarsal amputation in a neurotrophic foot with multiple ulcerations, patches of gangrene. Photograph taken five years after operation.

6. Massive, wet gangrene, ascending lymphangitis, high fever. Management consists of antibiotic preparation, guillotine amputation and secondary closure. Lower leg amputation often is feasible if popliteal pulse is absent. Absent femoral pulse necessitates thigh amputation. Prophylactic sympathectomy is worth considering on the opposite side (Fig. 10).

Errors in the Management of the Surgical Diabetic⁸

The failure of most amputations done in diabetic patients is not due to the poor selection of the level of amputation, but the great vulnerability of the terminal circulation. The following, rather customary procedures are to be avoided: Use of tissue forceps, sharp retractors, too many ligatures (although hematoma must be carefully avoided), suturing muscle and fascia to cover bone, tight skin closure and inadequate drainage, elastic bandages pulled too tight.

Toe amputation can be done by disarticulation if enough viable skin is present. The metatarsal amputations are done high, close to the tarsal joint (Fig. 11), to ensure good flaps. The lower leg amputation requires the greatest care and skill if it is to be successful. For supracondylar amputations, the method of Callander has been one of choice for many years (Fig. 12). For higher levels, only guillotine amputations are advisable.

Direct restoration of continuity by endarterectomy or by-pass procedure is feasible in patients whose occlusion is above Poupart's ligament, with no second or multiple occlusions below that level. Of course, terminal diabetic



FIGURE 12. Supracondylar amputation two weeks after operation. The stump was widely drained for 48 hours through the posterior flap.

angiopathy is not affected by surgery and may even be accelerated by it.

Summary

There is no single measure of proper management of diabetic neurovascular disease. Proper foot hygiene, including antiseptic soap, skin creme and chiropody eliminate the necessity of foot amputation in many instances. Incisions and minor amputations are often possible if arteriolar involvement is not too pronounced. Sympathectomies are useful 1) if there is demonstrable sympathetic activity with somatic nerve involvement, 2) if the level of amputation below the knee is questionable. Sympathectomies are useless in the dry, sympathectomized feet and in the presence of neurotrophic joints. Major amputations should always be done in an attempt to save the knee joint, if the patient will be able to use an artificial leg. Prophylactic sympathectomy of the other leg should be considered. Direct arterial surgery only occasionally is indicated.

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The Varied Role of Motivation in Obesity

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PHYSICIANS CONCERNED WITH MANAGEMENT of overweight soon become aware that lack of proper motivation in many patients is often thoroughly masked and difficult to expose. The fact that a patient may implore the physician to treat an overweight problem in no sense implies that motivation is extant; indeed, the physician is frequently expected to prescribe a drug possessing miraculous properties capable of providing a built-in substitute for motivation. Some patients travel many miles, eagerly accepting instruction and diet slips during frequent office visits. This course by no means establishes the hope of motivation that is required to enable the patient to lose weight on a permanent basis; it suggests only a willingness to travel long distances, pay fees, and accept medical instruction. The physician is still expected to provide an anti-obesity drug containing all the answers.

The lax attitude toward real or implied threats to the future health of many obese persons as related to motivation may comprise a startling point of view. Certainly, the challenge of a threatening cardiac episode or a distressing siege of diabetes should ignite an unswerving desire to follow dietary instructions. In many instances, the knowledge that a serious medical entity is extant suffices to cause an overweight person to "toe the dietary line." Oddly enough, however, an overhanging medical threat may be ignored and the attending physician is truly amazed and indignant to discover that his otherwise excellent patient will not follow a sustained reducing regimen. Indeed, many obese patients are not in the least interested in the effect excessive adipose tissue will have in the future; they think only

in terms of immediate cosmetic advantages to be derived by a more slender figure, of reinforcing a faltering ego and sometimes of fostering a possible nuptial ceremony, to name a few commonly encountered reasons.

With the latter attitude prevailing the physician may find himself confronted by a spirit of non-cooperation when the patient is admonished to "push himself away from the table". This is not to suggest that the physician is wasting his breath when he reminds his patient that obesity can damage future health; nonetheless, he should be fully aware that repetitious warnings often fall on unlistening ears and that other approaches should therefore be sought. A patient's motivation for losing weight can be bolstered by enumerating specific disadvantages to health; this is particularly adaptable to a person whose financial or emotional security is either already established or on the verge of accomplishment. Such a person usually realizes that his future health must be guarded at all costs. Contrariwise, in the case of less fortunate persons who are struggling to attain security or faced with the possibility that the goal may never be attained - the emphasis on health should not be ignored, even though the clinical response may prove disappointing.

Insight into the basic role that motivation plays in obesity requires some knowledge of the various types of obese patients seen in clinical practice. A pragmatic method for obtaining a more comprehensive understanding is to categorize different cases to a degree that will facilitate analysis and discussion. For the purpose of the point of view expressed in this article, several common types of obesity fre-

quently encountered by the authors may serve to demonstrate how motivating factors differ as they apply to individual obesity groups.

Familial Obesity

To illustrate familial obesity let us consider a female patient, ranging in age anywhere from 20 to 60 years, married, with several children. She is often constitutionally small, perhaps 5 feet, 2 inches tall, with fine features and an excellent complexion, having small hands and feet, and possessing an essentially happy, stable, uncomplicated personality. She is usually not a hypocondriac by nature. Her weight is likely to be excessive, as much as 60 to 70 pounds overweight, with a predominant fatty distribution in the breasts, upper arms, abdomen, hips and thighs. Her weight at the time she attended high school or when she married was probably 110 to 120 pounds. Following her first pregnancy, weight increase became a problem—a problem which became greater with each subsequent confinement. In essence she is a true "home-maker", delights in cooking for her family, joins their dietary excesses, does her own baking and housework, does not relish dressing up and dining out, and is not a club woman devotee. She may welcome visitors several times a day with something to eat and drink. A family gathering is replete with food and drink. Depending on the patient's ethnic origin, there is a strong liking for highly starched foods, rich and highly seasoned foods, and bakery goods. The eating pattern is inherited; obesity is not.

Under these circumstances, how strong is the motivation to lose weight? The patient feels well, is content with her lot in life, is not concerned with her dress size, and is seldom on public display. Her husband is equally unconcerned with her weight, for his home, family, and food requirements are expertly handled by his wife. Why then does the patient seek medical help? In all likelihood, because her children, reared in a weight-conscious America, have become sensitive to the implications of obesity. A few remarks passed by the younger members of her family are all that are required to prompt a visit to her physician. As so often transpires, the impetus is short-lived. Unless pressure from the family persists or the physician is aware of the poor status of motivation, the reducing regimen is doomed to failure. The patient may then yield to another form of pressure which results, more or less, in pseudomotivation. This is based on the patient's vague realization that to lose one's figure is alien to American mores, a social pressure, so to speak. Social pressure, however, is generally productive of half-hearted methods at reducing.

Lipophobic Obesity

In contrast to familial obesity, the obese lipophobic individual serves to demonstrate a number of pronounced differences. As the name implies, there is a fear of being fat. Lipophobic obesity is often linked to a hatred of excess poundage. Women are generally afflicted; they are, as a rule, constitutionally small, with delicate features and a slight bony structure. At one time, they may have been 20 pounds overweight. Fear or hatred of being fat will induce a successful attempt to stave off unwanted adipose tissue. Nevertheless, despite normal weight, the obese lipophobic patient continues to have the same conflicts that prevailed before her loss of weight. She is on a perpetual diet and manifests a definite tendency to seek medical advice in order to reduce still further.

A physician will often find this patient most difficult to manage, especially since she constantly demands prescriptions containing larger and larger amounts of anorectic drugs. One may question the advisability of having a physician accept this type of patient for therapy in the first place. The therapist should never minimize the psychic disturbances that are revealed by the patient. It is always possible that an outlet of greater magnitude may be substituted for the lipophobia. Furthermore, it is the physician's responsibility to introduce gentle withdrawal of the potent cephalotropic drugs the patient continues to demand.

Lipophobic mothers often demand that their overweight offspring be placed on an antiobesity regimen. Often enough, a child is unwillingly dragged to the physician's office by an insistent lipophobic mother whose frantic cries sometimes culminate in a life-long state of frustration in the child. Due to the parent's lipophobia and the incessant claim that she "hates fat," the child will frequently interpret

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this assertion as an expression of hatred because she is oversized and overweight.

It is readily ascertained that this type patient represents motivation at the highest possible level; so high, in fact, that the unresolved conflicts regarding fear of extra poundage disturbs her own peace of mind as well as that of the immediate members of her family.

Non-rapport Obesity

Non-rapport obesity presents another type of motivation peculiar to it alone. A female patient falling under this classification is expert at calorie-counting, is familiar with commonly employed diets, and literally exudes pessimism when the physician seeks to aid. She is apt to be a most skeptical and aggressive person; in fact, one of the most difficult obese types the physician may encounter. If anything, she is not passive.

The history will reveal that throughout life she has been on and off diets, her weight fluctuating between 30 and 40 pounds. She is found to be an alert, perceptive woman with many striae on the face, upper arms, thighs and abdomen. Most non-rapport patients are accustomed to rather potent dosages of the amphetamine compounds. Most are loathe to change their dietary habits, to improve improper habits they have been practicing for years. It usually astonishes the physician to be confronted by a patient during the first interview who rejects a truthful explanation of the exact nature of her weight problem and clamors for still another crash diet and potent anorectic preparation that have proved useless in repeated reducing regimens.

This patient is the victim of vacillating motivation; should one chart its clinical course, extreme peaks and valleys would be shown. At the high points of the curve, motivation is as thoroughly pronounced as that seen in the lipophobic obese, and since a thorough knowledge of calories and dieting exists, weight loss can be dramatic indeed. On the other hand, when motivation is in the depths of the valleys of the curve its status is as low as that presented by the familial obese.

In the face of the three rather distinctive types of motivation displayed by the familial, lipiphobic, and non-rapport obesities, it is small wonder that the physician's admonitions about health and "pushing away from the table" occasionally fall on unresponsive listeners.

Puberal Obesity

Puberal obesity and developmental obesity are the two clinical types recognized in the younger generation of patients. To illustrate factors influencing motivation in youngsters these two types will be considered.

Puberal obesity, which, as the name signifies, occurs during puberty, is characterized by a pronounced increase in size and weight. When this becomes evident to child, parent and the outside world, the physician is frequently consulted. The weight-afflicted youngster usually exhibits indifference to medical consultation and is often bored by the thought that increased weight and size comprise a problem. The physician may find himself believing that no rapport between the patient and himself is possible, yet he will attempt to improve their relationship in a calm, quietly interested way.

The weight gain, or size of the young patient may be either minimal or quite pronounced. The eating pattern of a puberal obese patient encompasses a strong desire for starches and carbohydrates, soft-drinks and frequent snacks. Indeed, there is little or no regularity to the pattern of eating. While some children are prone to sedentary habits, others are quite active. A discerning physician will readily recognize that the youngster has no motivation to lose weight; whatever motivation exists is of parental origin.

In puberal obesity the child is blessed with sufficient emotional stability to enable him or her to weather this teen-age problem. These patients often have parents that are mature and understanding and thus there is a stable and affectionate home environment. The developmental obese group, on the other hand, seems to present emotional problems of a more profound degree, a factor frequently discernable in one or both parents.

Therapy should deal with mild measures aiming to prevent an additional increase in weight and not an actual loss. Both parents and patient should be firmly advised of this objective. When a normal and gradual fondness for the opposite sex occurs, together with a mounting interest in sports and school activities, the patient will for the first time spark necessary motivation for controlling overweight independent of outside influence. Frequently the combined efforts of an understanding physician and parent lead the way to this happy conclusion.

Developmental Obesity

As in the case of puberal obesity, developmental obesity also has its inception in the preteen or teen-age youngster. Here, the role of motivating factors is not entirely clear-cut. Patients afflicted by developmental obesity may be doomed to spending a lifetime in quest of a satisfactory answer to the tantalizing problem of excess weight produced by lack of proper medical guidance during the formative years, and by the absence of insight into the nature of overweight. The clinician must recall that dietary habits comprise some of the most complex facets of human behavior. When a physician attempts to alter the food patterns of patients he deals not only with daily caloric requirements but also with a highly complicated behavior pattern involving a delicate interchange of biological, psychological and cultural influences.2

A classic example of developmental obesity is supplied by a young person who experiences a rather sudden gain in weight or size. Instead of being supported by a calm, stable, unemotional attitude on the part of the family, the patient often finds himself in a climate of opposing reactions. Too many arguments, threats, tears and other emotional scenes emphasize the battle of the bulge. In a surprising number of instances, a mother will reveal lipophobic tendencies. She is guilty of literally forcing her unfortunate child to adopt an unwanted and poorly understood "diet." Only when parental and patient frustration assumes unusual heights is the physician consulted. Occasionally a father who 'hates fat' will initiate the medical appointment. Sometimes the father becomes weary of endless arguments at the dinner table between mother and child and insists on consulting a physician.

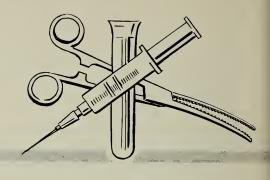
The eating pattern is similar to that extent among young puberal obese patients. In some instances, however, satisfaction is perceptibly more difficult to obtain; undoubtedly, there is much surreptitious consumption of candy bars, potato chips and the like because of scenes initiated by gastronomic demands. During the initial interview, a physician will soon sense that the parent has forced the issue of overweight and that emotional upheavals among members of the patient's family are likely to ensue. The mother will frequently do all the talking while the unhappy young patient glares resentfully.

Equating the status of motivation in developmental obesity may be extremely difficult. The chain of events leading to this particular state are often varied and obscure. Nonetheless, the authors of this article have repeatedly observed the following clinical picture. A patient will be found to have been raised in an environment in which the normal ego has never been satisfactorily checked by the parents. From time to time the parents are devotees of what has been described as the permissive school of thought in child rearing. Everything is done for the child; he has no delegated responsibilities; his every whim and desire is fulfilled without question. When the child gains in weight and increases his size, the parent assumes responsibility instead of placing the blame where it belongs, on the youngster himself. When all efforts of the parents fail to correct the dilemma, the physician is then appealed to for help in bringing about a desired loss in weight. The patient has yet to accept full responsibility for his obesity. Under these circumstances, the physician is confronted by a difficult situation whose solution requires an accurate appraisal of motivation which will vary with different individuals. At best, circumstances, often beyond a patient's personal control, will generate success or failure in the treatment of developmental obesity.

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Anesthesia Conference



COOK COUNTY HOSPITAL

Continuous Control in Spinal Anesthesia A Prerequisite to Safety

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THE SAFETY OF SPINAL ANESTHESIA is directly proportional to its controllability. If the principles that allow control of this technique are not carefully followed, safety is not achieved. The following case report illustrates how such a loss of control in the older age group may result in disaster.

Case Report

An 86-year-old white male was admitted to the fracture service with a history of having fallen from a sofa with resultant injury to his right hip. The remainder of the history was negative except for occasional ankle swelling for the past two or three years and symptoms of prostatism. On admission, the patient had a blood pressure of 162/86 mm. Hg and a regular

pulse of 77 per minute. Physical examination revealed an asthenic, somewhat dehydrated white male whose chest, though markedly emphysematous in configuration, was clear on auscultation. Examination of the heart was negative except for occasional premature ventricular systoles. The other significant physical findings included 2+ ankle edema, a moderately enlarged prostate, 2+ stool benzidine, and the externally rotated, shortened right leg, associated with fracture of the right hip.

X-rays of the chest showed the heart and lungs to be within normal limits, while views of the pelvis revealed a fracture of the femoral neck with coxa vera deformity. The hematocrit was 40 per cent; the urine contained albumin (2+) and many white cells. The fasting blood sugar was 58 mg. per 100 ml., the blood urea nitrogen 21 mg. per 100 ml., and the total protein determination 6.0 mg. per 100 ml. with an albumin globulin ratio of 3.2/2.8. The liver profile was within normal limits.

On the preanesthetic visit, phenobarbital 200

This article was developed from notes of a recent Cook County Hospital Anesthesia Conference.

mg. was ordered as premedication; however, when the patient arrived in the operating room, he was agitated and uncooperative, and the anesthetist questioned whether the prescribed medication had actually been administered. Blood pressure at this time was 120/70 mm. Hg and the pulse was 84 per minute and regular. The patient was placed in the lateral position and lumbar puncture was accomplished via the third lumbar interspace. After 8 mg. of hyperbaric dibucaine (Nupercaine®) had been injected, the patient was allowed to remain in the lateral position for about seven minutes. He was then positioned on the fracture table with the anesthetic level subsequently rising to the level of the seventh thoracic dermatome. The blood pressure began to fall immediately, so a solution of phenylephrine (Neo-synephrine) 5 mg. in 250 ml. of normal saline was quickly started by continuous drip. In this way, the blood pressure was maintained at about 100/60 mm. Hg, with the pulse remaining at about 120 per minute. Oxygen was administered throughout the surgical procedure, which consisted of insertion of a Smith-Peterson nail. The total procedure lasted 1 hour and 45 minutes and involved less than a 100 ml. blood loss.

Following this, the patient was sent to the recovery room, where the blood pressure had to be maintained artificially with vasopressors. When the patient developed cyanosis and dyspnea, an emergency electrocardiogram was taken and this showed definite S-T segment depression. In the fifth postoperative hour rales were heard in the right lung field with decreased breath sounds, but without neck vein distention. Cedilanid 0.5 mg. was given intravenously, but 30 minutes later the patient expired.

Discussion

The relative advantages and disadvantages of general and regional anesthesia might be profitably assessed. However, for the purposes of this discussion we shall assume that regional anesthesia has been selected and proceed to define how such anesthesia can be safely and effectively administered to the poor risk octogenarian described in the case report.

Controllability of the duration and height of anesthesia is the aim in regional anesthesia.

The continuous technique furnishes the anesthesiologist with a method for finer control of both duration and level, whether the choice of anesthesia be subarachnoid or peridural. Since the sympathetic blockade is ultimately similar in either type of intravertebral block, and since the subarachnoid approach allows more instantaneous control of analgesia, we feel this is the superior technique. Furthermore, the use of the differential spinal technique¹ might be utilized to further advantage by maintaining the concentration of anesthetic in the cerebrospinal fluid between the critical sensory and motor levels.

Using the continuous spinal technique, small doses of the anesthetic agent can be given fractionally until the level of analgesia is sufficient but not excessive. Duration of a single injection of the agent is unimportant with this technique, so a further advantage becomes apparent, i.e., the less toxic, short-acting agents may be utilized. Procaine thus becomes the drug of choice, since its cytotoxicity is one-tenth that of tetracaine and one-fifteenth to one-tenth that of dibucaine² (the latter drug even being capable of demyelinization). In addition, the relative systemic toxicity of Procaine is one-tenth that of tetracaine and one-twelfth that of dibucaine, as determined by intravenous injection.3 The patient described in the case report was not only exposed to an excessive dose of the potentially toxic dibucaine, but also to the deleterious effects of decreased cardiovascular tone, decreased tussive ability,4 and possibly even decreased pulmonary function,5 all of which persisted two to three times the duration necessary for surgery. Procaine administered via a spinal catheter would have provided a relatively nontoxic anesthesia that could be truly discontinued at the completion of surgery.

Although the undesirable effects of spinal anesthesia are minimized by this technique, they nonetheless should be anticipated and treated prophylactically. Prior to the performance of the block, the patient's legs should be wrapped and vasopressor solution prepared. Oxygen should be administered by mask as soon as the patient is returned to the supine position. In patients with cardiac disease and in all elderly individuals, the pressor agents should be in a concentrated enough solution so as to be effective without the administration of

large amounts of fluids. Such agents should have central as well as peripheral effect. Neosynephrine and vasoxyl exert their effect solely on the peripheral vascular bed. A better choice would have been aramine (metaraminol) which has a desirable central effect as well. Such therapy should maintain the blood pressure at a level more nearly that of the patient's normal, which in this case must be assumed to be that obtained on admission to the hospital, not that observed on arrival in the operating room.

Although atropine as premedication is indicated in somewhat reduced dosages in the aged,6 it is considered that sedation is usually not necessary. The majority of patients over age 60 have a conciliatory attitude toward most contemplated surgical procedures. In our department the use of narcotics is prohibited over the age of 60 due to their adverse effects on the cardiovascular system. Barbiturates have the additional effect of causing agitation and excitement secondary to cortical depression. Phenobarbital is one commonly used barbiturate that has almost no effect on the cardiovascular system and is the least likely to result in excitement. It is therefore doubtful that this patient's increased agitation and decreased blood pressure were due to his premedication.

Indeed, it is certainly possible that these were the signs of a medical catastrophe that had already occurred. Whether such was the case, or whether such a catastrophe developed secondary to the prolonged reduction in blood pressure with resultant hypoxia, the sudden onset of cyanosis and dyspnea postoperatively would seem to indicate the development of a myocardial infarction. The subsequent appearance of pulmonary edema was undoubtedly secondary to left ventricular failure. Management of such an emergency demands the use of a cardiac glycoside that is far more rapidly acting than cedilanid if the patient is to be

salvaged. This patient died 30 minutes after the administration of the cedilanid; the drug "did not have time to work." Acetyl Strophanthidin can accomplish immediate digitalization, with an onset in 4-5 minutes and a peak in 12-15 minutes. In addition, the duration of action is brief enough so as not to interfere with subsequent medical management.

Summary

The safety of regional anesthesia lies in its controllability. In the elderly poor-risk patient who is to receive regional anesthesia, continuous spinal is the choice since it affords the greatest amount of controllability. It allows the use of less toxic, short acting drugs, avoids an excessive level and duration of anesthesia, and minimizes the adverse effects of spinal anesthesia on the cardiovascular and respiratory systems. Such patients should have their legs wrapped prior to the block, and should receive oxygen by mask immediately thereafter. Choice of vasopressor should be one that has central as well as peripheral action, and these drugs should be prepared prior to the block in solutions that are concentrated enough to be effective without necessitating the use of large volumes of fluid. A case report is presented to show the disastrous results that can follow spinal anesthesia when one does not have adequate control of the anesthetic and does not treat the complication vigorously enough.

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The View Box Franz Gampl, M.D., Chicago

This 2-month-old infant was seen at the Pediatric Clinic with an indolent, hard swelling over the right parietal region. This was first noted at the age of 6 days. At that time the tumor felt soft and spongy. He was a full term baby of a primipara. The mother did not recall any complications during pregnancy or delivery.



FIGURE 1. Posterior-anterior view of the skull.

What is your diagnosis? Soft tissue abscess Caput succedaneum External cephalhematoma Meningocele

(continued on next page)



FIGURE 2. Right lateral view of the skull.

From the Department of Radiology, Cook County Hospital

The View Box — diagnosis and discussion

(continued from preceding page)



FIGURE 3. Enlargement.

The diagnosis is cephalhematoma.

Roentgen Findings: In the early stage the tumor has the appearance of a soft tissue mass overlying the external surface of a cranial bone. This tumor is strictly confined to the outline of the bone. The swelling does not cross the suture lines of the skull. The sites of predilection are the parietal and occipital area. Bilateral involvement is not uncommon. Close scrutiny of the radiograph will not infrequently disclose an associated linear skull fracture. The fractures are best demonstrated on the lateral view. A shell-like calcification can be seen after 2-3 weeks accounting for the characteristic roentgen appearance.

Etiology: Trauma during infancy and early childhood may injure the delicate vascular structures between the periosteum and the outer table of the skull. The resulting hematoma leads to detachment of the periosteum. Cephalhematomas occur with varying frequency in 0.4% to 2.5% of all births. They develop more frequently after forceps deliveries. Infants of primaparas show an increased incidence of cephalhematoms. Hypoprothrombinemia may constitute an additional factor, although vitamin K administration to the pregnant mother

has not changed their incidence in the newborn.

Pathology: The sub-periosteal hematoma is confined to the boundaries of the cranial bone by the firm attachment of the periosteum. Periosteal new bone formation is demonstrated after 2 weeks, resulting in marginal calcification of the tumor.

Course: The newly formed bone is usually absorbed in a few months. Thickening of the calvarium or cystic changes may, however, in some cases persist during childhood and into adult life. In these cases they have to be differentiated from epidermoid cysts, osteomas, localized fibrous dysplasia and sclerosing meningeomas.

Severe bleeding into a large cephalhematoma, associated intracranial hemorrhage, infection and meningitis are uncommon.

The uncomplicated external cephalhematoma with or without underlying linear skull fracture requires no treatment. Aspiration of its contents is to be avoided.

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MEDICINE in the OUT-OF-DOORS

Some Stinging Pests of Humans

Julius M. Kowalski, M.D., Princeton

THE EVOLUTION OF ALL HIGHER flora and fauna and the very development of the human species is intimately interrelated with the class Insecta (Hexapoda). In total species and in actual numbers they comprise about 75 per cent of all living animals on earth. This superiority has been theirs for two hundred fifty million years, and the size of some specimens from that ancient geological period would be frightening to face today — say, dragonflies with a wingspread of almost 3 feet. Man is the intruder in *their* world, a newcomer with a brief history of one million years.

Despite the many attributes of flying, crawling creatures in the over-all scheme of natural phenomena they are frequently annoying and on occasion dangerous to man and beast. The garden variety of pests frequently encountered in the pursuit of outdoor activities will be discussed.

They have several features in common: Exhibit greatest activity during the warm weather and daylight hours; live in colonies; and when one is seen, others are nearby. Windy, overcast or rainy weather often inhibits their functions.

Bees

These pollinators are most important to agriculture for significant yields of clover, alfalfa and fruit and, of course, in the production of honey. They are attracted to colorful or fragrant blossoms and nectar. By avoiding a profusion of flowers in the garden or woodland, or patches of blooming clover or alfalfa, one is less likely to suffer bee stings. Colorful dress, as often worn by children and women in warm weather, attracts bees - perhaps for the same reason that they are attracted to flowers. Dark colors hold a greater affinity for them than does white. In many instances when Holstein cows are attacked, most of the stinging is done on the animals' black areas, whereas the white ones are spared. Bee keepers wear white when tending hives to minimize attacks. Fragrant cosmetics on women attract men - and, unfortunately, also bees. Quick erratic movements — the very instantaneous reactions most of us exhibit when beset suddenly - incite bees. When in such a predicament, one should move out of the area slowly — easier said than done.

The stinger of the worker bee possesses recurved hooklets at its terminal end. When driven into the skin, it cannot be withdrawn by the insect. The entire stinging apparatus is torn from its body in regaining flight and sometimes pulsations of the associated structures can be observed. The stinger should be removed as quickly as possible with fingers or preferably with tweezers, since swelling can be severe within a few minutes from the venom, obscuring the puncture site. When this happens

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the stinger sets up a foreign body reaction with attendant complications. The large bumblebee, however, has a smooth stinger and can make repeated attacks.

Hornets

The two common hornets in the U. S. are the baldfaced (known as whitefaced or black hornet), and yellow hornet. The latter is often confused with the yellow-jacket wasp. Hornets hover above the ground or in foliage, seeking out caterpillars as a source of protein for their growing brood in the hive. At times the hornet will strike a person with stunning swiftness and without provocation, but most often makes no attempt to attack.

The hive of the baldface hornet is the familiar grey paper nest about the size of a football suspended from a tree limb. Observe this abode from a distance! Attempts to dislodge it with a stick or by throwing stones at it, as is the wont of boys, will literally lead to stirring up the hornets' nest. With keen vision they are quick to spot the intruder and inflict painful retribution.

Wasps

There are many varieties of wasps. The outstanding identifiable characteristic is the body with the constricted waist, as if the abdomen were attached to the forebody by a coarse thread. They feed almost exclusively on other insects or deposit their eggs in or on them so that their developing larvae eventually destroy the host. They, too, build a paper nest which is suspended from a limb or under a building eave and resembles an inverted champagne glass in size and shape. The openings to the cells are on the underside. Because of this nesting habit near buildings, they can be a nuisance.

They sting viciously when molested, but the benefits from their predaceous habits far outweigh these objectionable traits.

Yellow-jackets

These black and yellow, striped, full-bodied insects feed on plant and insect juices and on overripe fruit. Some species build large globular paper houses, suspending them from buildings or limbs; others build their nests in the ground. Their colonies are often large, and their attacks on humans are ferocious in that each insect can inflict a number of stings.

Should one be so unfortunate as to discover numerous vellow-jackets about a lake cottage he has just rented for a two-weeks' vacation, this insect's preference for animal juices can be used in its eradication. Freshly-caught fish are skinned or filleted and suspended above a pail or other receptacle about three-quarters filled with water. Several such setups should be placed around the area but well away from the cottage. Yellow-jackets will soon find the fresh morsels, gorge themselves, and when distended to the point where flight temporarily is not possible, will then drop the few inches into the water below and drown. Fresh setups should be replaced daily; they attract flies, too, but after several days the number of vellowjackets will be materially reduced to the relief of all concerned.

To eradicate a hive of hornets or wasps in an attic or garage one should observe the insects by daylight (at a safe distance naturally) to determine the openings used by them. These entrances should be sealed appropriately since if they are not, though the hive be destroyed, other insects will again use the same avenues of egress. Then at night, after the exterminator is clothed in heavy jacket, gloves, and hat with netting over face and neck, an aerosol can of DDT with sufficient pressure is used to quickly and thoroughly spray the hive entrance. This process may have to be repeated for several nights before the hive can be safely removed.

Hives of bumblebees and wasps who make their nests in the ground should likewise be closely observed, since there may be several entrances. These are also sprayed after dark or buried under earth of sufficient depth—more than just a few shovelfuls.

The sting of all these insects is excruciatingly painful, and marked swelling and redness appear quickly thereafter. An effective first-aid treatment is the application of cold to the afflicted area, preferably ice. If the sting is on an extremity, then the entire hand or foot should be immersed in a mixture of ice and water. The cold minimizes pain and reduces swelling as the venom is slowly detoxified. This

treatment may be continued for several hours or longer. On other parts of the body an ice bag or ice cubes in plastic will do. A paste of baking soda or cold packs of ammonia water to the injured site act as counterirritants and in part alleviate the pain.

Persons receiving multiple stings, especially children, elderly persons or anyone with allergies, should seek medical attention immediately since the victim's condition can deteriorate rapidly. Persons who have been stung before may need quick, vigorous medical treatment.

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Intravenous Use of a Specific Antiemetic in Surgical Patients

Ross Schlich, M.D., Donald Clark, M.D., and Edward Evenson, M.D., Springfield

THE NEED FOR A PRACTICAL ANTIEMETIC to counter nausea and vomiting associated with the administration of anesthesia is reflected in the widespread use of many nonspecific agents such as the anticholinergics, antihistaminics and phenothiazine derivatives with their numerous congeners. Some of these drugs are effective in this secondary role (although their antiemetic effects may be incidental to a more specific pharmacological action), but their usefulness is often nullified by undesirable and sometimes dangerous side effects.¹

Our department of anesthesiology, in a private hospital of fewer than 400 beds, is concerned with a problem common to all anesthetist-surgical teams: reducing postanesthetic retching and vomiting safely and effectively. Within the limits inherent in a small hospital, the objectives are likely to be insular and the methods simple and practical. For this reason we were looking for an antiemetic which would bring prompt relief to our postsurgical patients without initial risk or ensuing sequelae.

An apparent solution to our problem came with the introduction of trimethobenzamide (Tigan®).* Our interest in this relatively new drug stemmed from its reported specificity as an antinauseant and antiemetic. Its mode of action

is believed to be a blocking of the chemoreceptor trigger zone² (in the floor of the fourth ventricle, dorsolateral to the vagal nuclei)³ from which emetic stimuli are relayed to the vomiting center in the underlying reticular formation of the medulla.³ The fact that Tigan in clinical trials⁴⁻⁶ had proven free of undesirable side effects was sufficient argument for adopting it as an ancillary agent in our surgical practice.

No one would minimize the misery of nausea and vomiting to the postsurgical patient; nor would one fail to recognize the potential hazards of retching and emesis in causal relation to wound disruption, electrolyte imbalance or to aspiration of vomitus. Yet, since fewer than 4 per cent of surgical patients present more than transient nausea and vomiting,1 there is the temptation to let these symptoms run their course rather than subject the patient to possible pharmacologic insults. For example, it is hard to justify the successful relief of retching if the patient has been made dangerously hypotensive as a consequence. Thus, we took special precautions in employing Tigan intravenously and were particularly on the alert for possible untoward reactions.

Pilot Study

Prior to this investigation, we conducted a pilot study to establish an "incidence index" of postoperative emesis which would reflect our surgical population and our anesthesia-surgical methodologies more accurately than the incidence figures in the general postsurgical popu-

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^{*}Trademark of Hoffmann-La Roche Inc., Nutley, New Jersey.

lation. We took into account a number of the variables which have a direct bearing upon the amount and degree of postoperative emesis, e.g., age and sex of surgical candidates, types of surgery and operative procedures, type of premedication, the nature of the anesthetic employed, duration and level of anesthesia, and the skill and experience of the anesthetist-surgical staff.⁷

The pilot study findings in a series of 339 postsurgical cases showed a 14.5 per cent incidence of vomiting recorded in the recovery room. Patients experiencing a transient retching in the operating room which subsided before their transfer to the recovery unit were not recorded in the incidence index.1 Taken into account were the following factors: 1) the inclusion of all types of surgery, excepting cardiac operations; 2) exclusion of patients under age 16 (thereby eliminating ether anesthetics often employed in younger surgical patients); 3) restriction of the anesthetics to those containing about 60 per cent of either Fluothane or nitrous oxide as their primary agents8 (both with low emetic indices); 4) the 6-year experience level of our anesthesia staff.⁷

In view of these factors, our 14.5 per cent figure appeared comparable with the accepted standard of 18 to 28 per cent;^{1,9} therefore we were satisfied to begin the investigation of Tigan.

Procedures and Materials

Two phases of investigation were pursued: prophylaxis and therapy. Consequently, two separate groups of patients comprised the study.

Group I: This group comprised 528 surgical patients, while under anesthesia given 200 mg. (2 cc.) of Tigan intravenously as prophylaxis against nausea and vomiting. The content of the 2 cc. injectable ampul of the drug was introduced into the sleeve of the I.V. tubing approximately 15 minutes before anticipated termination of surgical procedure. The rapidity of the Tigan flow was governed by the speed of the replacement fluids, which were allowed to run briskly during the addition of the drug, thus giving considerable dilution during administration.

This phase was initiated in the operating room — first, because all subjective response

would be eliminated since the unconscious patient could not be aware of special medication; secondly, because it afforded opportunity for close observation for possible side effects or unexpected reactions. Throughout drug administration patients were closely observed for any alterations in blood pressure, pulse and respiration. Observation continued after the patient's transfer to the recovery room.

After we were satisfied that the intravenous administration of this drug would cause no untoward reactions, we began a second phase of investigation directed to the treatment of established nausea and vomiting.

Group II: This group comprised 144 (out of approximately 1000) postsurgical patients who had nausea and/or vomiting after transfer to the recovery room. Using the previously established criteria for inclusion in this phase as for the control patients and for Group I, Tigan was given in 100 mg. doses intravenously. Observations again were directed to any noticeable changes in blood pressure, pulse and respiration, as well as to any prolonged state of unconsciousness which might indicate a possible potentiation by the drug of residual premedication or of uneliminated anesthetic.

Results

Group I—Prophylaxis. Of 528 surgical patients (180 of whom had undergone abdominal procedures), 51 (9.7%) had nausea and vomiting. In a breakdown as to relative onset of emesis, 38 (7.2%) patients experienced vomiting before leaving the operating room; 42 (8%) vomited in the recovery room; 29 (5.5%) in both OR and RR. Using the recovery-room pilot study as a control group (14.5%), a recovery-room comparison with the treated group (8%) showed that Tigan had produced a 6.5 per cent reduction in nausea and vomiting.

Close observation in both locations revealed no change in blood pressure, pulse or respiration in the entire 528 cases. Two patients showed wheal formation along the course of small communicating veins near the site of the I.V. needle. This histamine-like effect disappeared spontaneously within half an hour.

Group II—Therapy. The incidence of nausea and emesis in approximately 1,000 patients coming to the recovery room numbered 144.

Of these, 119 (83 per cent) were relieved by intravenous 100 mg. doses of Tigan; a few patients required a second dose for complete recovery from nausea. Failure to relieve emesis was recorded in 25 (17%) patients. A failure was registered if no relief occurred following a second dose 10 to 20 minutes after the first.

The average time of onset of nausea was 27 minutes after the patient entered the recovery room. It ranged from immediate appearance to 4 hours in different patients. Onset of relief of nausea and emesis following I.V. Tigan averaged 17 minutes and varied from 5 to 30 minutes.

The duration of the drug's antiemetic action appeared capricious; some patients who responded promptly (within 10 minutes) experienced a return of nausea an hour later. However, they responded satisfactorily to a second dose. The expected 3-to-4-hour duration of the action of Tigan⁵ was not always substantiated in our two series.

In no instance were alterations in blood pressure, pulse, respiration or consciousness observed. One patient was given Tigan directly into the vein slowly. She complained of stinging along the course of the vein, proximal to the injection site, and at the same time experienced what she termed "a funny taste."

Discussion

Because of Tigan's direct action on the chemoreceptor trigger zone, and its less direct influence upon the reflex visceral impulses stimulating the vomiting center,2 careful attention should be given to the cause of the nausea and emesis. Thus, one might predict when to employ Tigan for optimum effectiveness. By evaluating the etiology of the vomiting, the surgeon or clinician might better determine whether Tigan or another antiemetic agent, or none, is indicated. It would be unthinkable to give Tigan for retching from hypotension during spinal anesthesia when a vasopressor would solve both problems. Similarly, if nausea were secondary to hypotension from hemorrhage, no one would want to substitute Tigan for blood. Theoretically, one would expect nausea and vomiting to be poorly controlled in the patient suffering from a significant quantity of bile regurgitated into the stomach, or in the patient who has swallowed copious amounts of other. By the same token, one would expect little relief from retching or nausea induced from mesenteric pull during spinal anesthesia. It was surprising, therefore, to obtain prompt relief from Tigan in two such cases. Two patients under spinal anesthesia for Caesarian section, who were nauseated by mesenteric pull, were promptly and completely relieved in less than five minutes by this agent. Similarly beneficial effects in these cases have been reported by others. ^{1,9} Another investigator ¹ points out that Tigan is virtually the only antiemetic that can be used with impunity in spinal anesthesia, especially intravenously, since this drug has no sympatholytic effect. ⁹

After studying the preliminary reports of others and the experience of using Tigan intravenously in 672 patients, we are convinced of the safety and specificity of this drug. These attributes make it the most nearly ideal antiemetic, though not always the most effective; thas but slight effect upon ether-induced emesis. It is our impression that the persistent and stubborn cases of vomiting usually remain resistant to this agent.

In Group II, however, approximately 70 per cent of patients either nauseated or vomiting were promptly relieved by Tigan; another 10 per cent were helped, though not as completely. The safe elimination of 80 per cent of our emesis problem commends Tigan for further intravenous use in our hospital on an experimental basis.

Summary

- 1. Tigan was administered prophylactically to 528 surgical patients in intravenous doses of 200 mg. (2 cc.) approximately 15 minutes before the anticipated end of the operative procedure. The incidence of nausea and vomiting was reduced about 7 per cent as compared with that of a control group numbering 339 patients. The significant finding in this phase of our study was that Tigan administered intravenously was free of any serious side effects.
- 2. Tigan was given therapeutically in an additional 144 cases of established nausea and vomiting in the recovery room in intravenous doses of 100 mg. It was successful in 119 (83%) of postoperative patients and failed to effect relief in 25 (17%).

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- 3. No significant deleterious effects were observed in the 672 cases of intravenously-administered agent. Two cases of wheal formation along small communicating veins near the site of the I.V. needle resolved spontaneously within one-half hour. We recommend injecting the drug into the sleeve of the I.V. tubing with the flow of fluids speeded up for one or two minutes. The one unsedated patient to whom the drug was administered by direct venipuncture found it unpleasant but tolerable.
- 4. Although it was not without appreciable failure and may not always be the most effective agent, the specificity of Tigan as an antiemetic and its relative freedom from side effects were unequivocally demonstrated in our study. Close observation showed no alterations in blood pressure pulse or respiration in any of our 672 patients.

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When one knows that a con-Congenital genital cataract is becoming an Cataract impediment to visual acuity, a

debatable question arises: "When should it be operated upon?" Here authors are not in complete agreement. According to a statistical report by Papapanos and Schenk on the results of operation for cataract during the first ten years of life, children with congenital cataract due to fetal iridocyclitis have little vision after the operation, which should therefore not be performed until the child is 4 or 5 years old. In cases of total congenital cataract of both eyes, without inflammatory processes, and in cases of incomplete cataract with severe involvement of both eyes, operation should be performed during the first year of life; otherwise, as has been pointed out by Chandler, nystagmus will appear owing to the lack of proper visual acuity. When only one eye is affected by a dense cataract, amblyopia is bound to result in that eye even if this eye is operated on, since, as a rule, neither the child nor his parents will tolerate occlusion of the good eye long enough for the visual acuity of the surgically treated eye to increase significantly. In borderline cases, with moderate involvement of both lenses, it is best to wait and see how the child gets along. Again, it is best not to consider operation for some time, at least, when a child with bilateral dense central opacities can still obtain useful vision simply by having the pupils dilated. In cases of partial cataract it is best to wait for surgical intervention until the fourth or fifth year of life.

In general, one should keep in mind that operations done on children under 2 years of age give inferior results because of the incidence of complications. The parents of a child with congenital cataract, therefore, should be told about the dangers and pitfalls of surgical treatment and the limited results to be expected. Arthur R. Labelle, M.D. Treatment of Congenital Cataract. J. Internat. Coll. Surgeons. May 1961.

Clinical Significance of Raynaud's Phenomenon

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FIGURE 1. Trophic changes in fingers in severe (tertiary) Raynaud's disease. Left and center—superficial ulcers of the

tips of the fingers. Right—depressed scars in sites of healed ulcers in Raynaud's disease.

THE CONTROVERSY THAT EXISTS regarding terminology of Raynaud's phenomenon necessitates an attempt at classification. The following classification by Duff¹ includes at least three types of disorders, each having in common transient discoloration of the tips of the fingers or toes from exposure to cold or emotional excitation.

tively benign disorder, arising in early adult

1. Primary Raynaud's disease: This is a rela-Department of Physical Medicine and Rehabili-

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First of two parts. To be concluded in the July issue.

life, generally in women, but occasionally also in men.^{2,3} It is characterized by the tendency to demonstrate pallor of fingers. Despite repeated attacks of digital color changes, occurring over many years, no irreversible changes in the digits are apparent. Predisposing factors are generally not elicited, although there may be an inherited susceptibility to transient vascular spasm on exposure to cold or emotion. Gangrene of the digits is not observed.

2. Secondary Raynaud's disease (or, a better term—Raynaud's syndrome or phenomenon): In this condition there is also paroxysmal digital ischemia. It occurs at any age, in men and women, all of whom have already acquired some abnormality of the circulation either of the blood or of the blood vessels. It may result from repeated trauma, occlusive arterial vascular disorders, the various types of "collagen" diseases, etc. In some of these cases the mechanism which triggers the Raynaud's phenomenon is relatively obvious, while in others it is obscure or unknown. The prognosis with regard to the color changes is dependent entirely upon the underlying difficulty. Unless this is arrested or removed, the disease usually causes progressive organic vascular narrowing, which may result in tissue damage and gangrene of the involved digits.

3. Tertiary Raynaud's disease: This condition has three diagnostic features: 1) transient attacks of digital artery spasm, as noted in the other two groups; 2) progressive loss of tissue, starting at the tips of the digits and spreading proximally (Fig. 1); and 3) the absence of a demonstrable cause or of any abnormality in either the blood or the vascular tree of the unaffected portions of the limb. As a result, the diagnosis of this condition is often made late in the disease. Initial diagnosis is primary Raynaud's disease, but the episodes of digital artery spasm increase in frequency, duration, and severity, until the intervals between paroxysms are characterized by a persistent and progressive impairment of nutrition, leading to indolent ulcers and eventually to gangrene. In this sense, primary and tertiary Raynaud's disease could be considered as different stages of the same disorder, but without one necessarily following the other. The more serious phase is identified by a marked speeding up of the progression and severity of the pathologic process. At no time is an underlying difficulty recognized in either of these two conditions. This is in contrast with Raynaud's phenomenon, in which one is always present.

Clinical Picture

In all types there is a history of color changes of the digits, precipitated by cold and emotional excitation. Occasionally the alterations may consist of a triple response, i.e., pallor, cyanosis and rubor, in that order. There may be either cyanosis or pallor followed by rubor, or pallor followed by cyanosis without the subsequent appearance of rubor. However, pallor or cyanosis must be present in order to make the diagnosis.

Basis for Color Changes

Pallor is due to spasm or functional obliteration of the digital arteries supplying the fingers and toes. Because there is a resulting absence of arterial inflow during the attack without any simultaneous change in the venous tree, the cutaneous vessels soon become empty of blood and blanching ensues. Although the arterioles, capillaries and venules are considered only passively involved in this reaction, it is possible that the existing anoxia produces active spasm of the minute vessels of the skin, thus contributing to the characteristic waxy pallor.

Several explanations have been offered for the appearance of cyanosis. One is that spasm of the digital artery is intermittently released during the attack, permitting blood to enter the capillaries at a very slow rate. This results in stasis in the minute cutaneous vessels and the removal of a greater than normal quantity of oxygen from each unit of blood. As a consequence of the accumulation of reduced hemoglobin in the subpapillary venous plexus, the skin is colored blue. Another possibility is that blood is trapped in the superficial vessels during the period of arterial spasm. It also has been suggested that there is an associated venospasm, which, if predominant, will cause stasis in the digits, again furthering the loss of oxygen from the blood. In the absence of arterial spasm, it is believed that venospasm may produce cvanosis and even swelling, but never pallor.

On removal of the spasm of the digital vessels, as by exposure to warmth, there is a rapid dilatation of the arterioles, capillaries and venules and the resumption of local circulation. With the entrance of normally oxygenated arterial blood into the vessels at an increased rate, the skin displays rubor, a manifestation of reactive hyperemia. As complete recovery occurs, the skin assumes its normal tint.

Pathogenesis of Color Changes

Considerable controversy exists regarding the mechanism that initiates the spasm of the digital arteries. It is the opinion of some workers^{4,5} that the abnormality is in the sympathetic innervation of the vessels, while others^{6,8} believe that the arteries themselves possess an inherent increased sensitivity to cold. The latter view is supported by the finding that after sympa-

thetic denervation, as through sympathectomy, direct application of cold to the digits still elicits a definite, though reduced response. Although most other evidence corroborates this view, involvement of the sympathetic nerves cannot be entirely excluded.

Symptoms

Certain symptoms are associated with the episode of color change. During a period of pallor or cyanosis the patient usually experiences a sense of coldness, numbness, or tightness, and at times an actual diminution of sensory acuity in the involved digits. In some instances there may be no unpleasant sensations. As the attack wears off and the circulation is re-established, tingling, burning, throbbing, or paresthesia may be experienced. Between episodes no symptoms are present except possibly a subjective sense of coldness in the hands and feet.

Signs

Because the spasm is limited to the digital arteries, the color phenomena are present in the digits, usually being noticed first in the tips and later in one or two distal phalanges or even in all three. However, the process does not extend onto the rest of the hand or foot. One or more fingers or toes may be affected simultaneously, but rarely the thumbs alone. In most instances they are spared. Although bilateral distribution with symmetrical digital involvement has been considered one of the criteria in the diagnosis of the disorder, unilateral color changes may be observed, especially early in the onset of the difficulty. (To be concluded)

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Metrorrhagia in Adolescents

Functional uterine bleeding in adolescents is not uncommon and may be expected to be more frequent because of the normal anovulatory cycles which occur in the first few years of menstrual life. Often the adolescent ovaries produce a sustained, irregular, or excessive amount of estrogenic hormone. The vast majority of these patients will develop normal menstruation, and the main therapy is directed toward the control of blood loss and the treatment of anemia, temporizing until the natural sequence of ovulation, corpus luteum formation, and normal menstruation occurs. Thyroid extract, mild sedation, reduction of weight, and curettage (on rare occasions) may be helpful

in establishing normal cycles. Testosterone propoinate may be administered as stat doses for temporary improvement.

Of 48 adolescents with metrorrhagia treated by us in recent years, progesterone was administered in 50 mg. doses to 24, intramuscularly on alternate days for two days, repeated at 28 and 30 day intervals for four months. Menstruation subsequently was regulated and apparent cure achieved in all but one. In this instance, the patient proved subsequently to have a granulosa cell carcinoma of the ovary, apparently cured after local excision of the one ovary. Laman A. Gray, M.D. Treatment of Metrorrhagia in Adolescence. J. Kentucky M. A. May 1961.

Cystic Lymphangioma of the Pancreas: Case Report

ISADORE GUN, M.D., WILLIAM SCHUMER, M.D., and SECUNDINO VEIGA, M.D., Chicago, Illinois

REPORTS OF THE OCCURRENCE of cystic lymphangioma in the pancreas are rare. Although necropsy reports have been cited, 1,2 the rare recognition of this tumor pre mortem prompts us to report the following case in detail.

Case Report

An eight-year-old girl was admitted to hospital on August 13, 1961, complaining of abdominal pain for the past two days. Pain had started during the afternoon of August 11, 1961, and localized to the right lower quadrant. It was constant without radiation. The patient lost her appetite when the pain appeared, but had not been nauseated nor had she vomited. She had been having daily bowel movements. At admission temperature was 100° and pulse was 100. Previous history revealed similar attacks for the past ten weeks, spontaneously subsiding each time. Examination of the abdomen revealed a tender right lower quadrant. Mc-Burney's point was tender to palpation. There was guarding of the right lower quadrant and rebound tenderness, also hypoperistaltic bowel sounds. No masses were palpated nor organs felt. Rectal examination revealed moderate rectal tenderness at palpation of the right fornix.

Diagnosis on admission was of an acute appendicitis. Blood count at this time revealed hemo-

globin 9.2 gm.%, hematocrit 32 vol.%, RBC 3,510,000, WBC 7,400, stabs. 2, segmented 67, eos. 1, lymphs. 20, monos. 10. Urinalysis was negative except for 6 to 8 white blood cells and many bacteria. The patient was taken to surgery, where a lateral gridiron incision of the right lower quadrant was made. The appendix, once visualized, seemed normal. On opening the peritoneum a scanty amount of strawcolored fluid escaped; at the upper end of the incision a bluish-colored mass was seen, apparently from the upper abdomen. The appendiceal incision was closed without removing the appendix and a right paramedian incision performed. A large cystic mass, multiloculated, about 15 cm. in its largest diameter occupied the lesser omental sac with the base almost perforating the transverse mesocolon. The anterior aspect of the tumor perforated through the gastrocolic ligament. The most inferior aspect of the tumor pointed into the right lower quadrant.

On entering the lesser omental cavity a plane of cleavage was found. The entire mass could be dissected easily down to the anterior surface of the body of the pancreas, where the plane of cleavage disappeared. The pedicle was broad (about 5 cm. in diameter); it was clamped off and tied with black silk. The pedicle seemed to emanate from the body of the pancreas. A soft rubber catheter was left in the lesser omental cavity and brought out through a stab wound on the right upper quadrant.

From Mount Sinai Hospital, Chicago, Illinois

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FIGURE 1.



FIGURE 2.

Microscopic diagnosis was of a cystic lymphangioma of the pancreas. The postoperative course of the patient was uncomplicated except for an episode of paralytic ileus on the eighth day, nine hours after removing the rubber catheter from the peritoneal cavity. After that episode the patient responded well to conservative care, and was discharged from the hospital on August 26, 1961. When last seen in the outpatient clinic she was doing well, showing no evidence of postoperative complications.

Pathology

Grossly, the tumor appeared encapsulated, but a true capsule could not be identified in all the sections. It was received opened and most of the cysts were empty; however, some contained clear fluid and only a few clotted blood.



FIGURE 3.

It had a bosselated multicystic appearance. Some of the cysts had a very thin wall, particularly those in the periphery. The cysts in the center were separated by somewhat thicker septae (Fig. 1).

Histologically, this tumor is indistinguishable from the cystic lymphangiomas (hygroma) occurring elsewhere in the soft tissues and is composed of branching endothelial lined channels, many of which are cystic and contain amorphous acidophilic material. Their walls are formed by septae of fibroconnective tissue, tissue containing bundles of smooth muscle, adipose tissue, and focal accumulations of lymphocytes (Fig. 2). Pancreatic tissue compressed and separated by lymphatic channels was present in some of the sections (Fig. 3). Focal areas of granulomatous reaction were found in the septae in relation to cholesterol clefts.

Discussion

Since the clinical picture of this type of pancreatic cyst is virtually unknown, it would be well to try to crystalize pathogenesis of the symptoms. We can deduce symptomatology by studying this type, as well as other types, of pancreatic cysts. Cystic masses arising from the pancreas are restricted from growing posteriorly by structures of the posterior abdomnial wall, against which the dorsal surface of the pancreas rests. The cyst usually will present itself in the lesser peritoneal cavity and may press forward through the gastrocolic or gastrohepatic omentum. The subjective sympto-

matology of pancreatic cysts depends on the size and location of the lesion. Because of their pliability, large pancreatic cysts may produce no preliminary symptoms; or, if they become large enough as in this instance cause functional disturbance of adjacent viscera.

Figure 4 shows the apex of the cystic tumor ruptured through gastrocolic ligament and descended over the transverse colon down to the right lower quadrant. The anatomical position of the tumor may explain the rigidity in the right abdominal musculature. The tenderness in the right lower quadrant was probably due to the tumor partially obstructing the transverse colon, with subsequent distention of the cecum. Rebound tenderness can be explained on the basis of peritoneal fluid. On further questioning the patient gave a history of vague epigastric pain, explained by the extension of the tumor upon the upper gastrointestinal tract.

As previously indicated, cystic lymphangiomas (hygromas) are benign angiomatoses occurring more frequently in children and not uncommonly present since birth. Their true tumoral nature is not generally accepted and the possibility that they represent a hamartomatous malformation is supported by many. They may reach considerable sizes and their symptomatology is entirely limited to local disfiguration and extrinsic compression of neighboring structures.

The term Chylous cyst has been indiscriminately used to designate this type of tumor in the retroperitoneal space. We do not feel the location alone would be sufficient to introduce another term since the histological characteristics as pointed out are identical to lymphangiomas occurring in the tongue, mouth, neck or elsewhere.

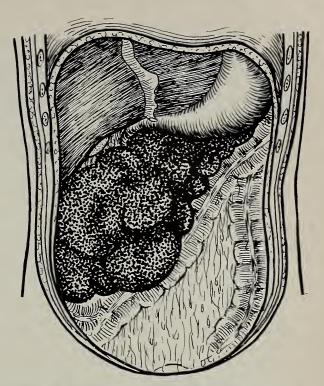


FIGURE 4. Drawing showing the extent, location and magnitude of the tumor.

Summary

A case of cystic lymphangioma of the pancreas has been reported for the following reasons:

- 1. Unusual location of the cyst.
- 2. This is the first pre mortem report of this type of tumor.
- 3. The pathogenesis of the clinic picture of this tumor has been discussed.

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Present Status of Selective Service As It Relates to Physicians

During the calendar year 1961 three Selective Service calls for physicians were issued. This was the first time such calls have been necessary for several years. However, during the past year there was a decrease in volunteers and an increase in the numbers required by the Armed Forces as a result of the mobilization program. This increase in requirement was obtained by:

- 1. Discontinuing the acceptance of resignation of Regular Officers.
- 2. Denying release of those Reserve Officers who had voluntarily extended their active duty for an indefinite time.
- 3. Selective Service call up of 1,025 physicians.
- 4. Call to active duty of National Guard and Reserve Units with Medical Officers attached.

Because physicians, dentists and other medical specialists, generally speaking, are liable for military service until age 35, and because they may be called as a special group, they were given the following considerations:

- 1. Those in a Reserve status who were called as filler personnel on or after September 1, 1961, and who had completed at least 21 months previous active duty were given the opportunity to be released shortly after the activation of the unit.
- 2. Those Reserve Officers on active duty serving only their required two years were released at the end of their tour.

The physicians called up by Selective Service were those in the youngest age group who had completed their internship. This group, there-

Prepared at the request of the AMA Council on National Security by Eugene V. Jobe, M.D., Medical Liaison Representative, AMA Washington Office, and James E. Fitzgerald, M.D., Member, AMA Council on National Security, April 9, 1962.

fore, included almost exclusively first year residents and physicians just beginning private practice. Since the call was based on age it was not evenly distributed and some hospital training programs suffered a depletion of their first year residents while others were untouched.

Because of the possibility of future Selective Service calls for physicians in time of a crisis it would be well to consider the measures which are available to ameliorate the effect on hospital staffs and civilian communities. These are:

1. Appeal of classification of 1-A (available for military service) to the Appeal Board.

Shortly after completion of internship, physicians are normally classified by Selective Service in Class 1-A. An appeal may be made within ten days after receipt of this classification by filing with the local board a written notice of appeal. If the physician is located in an area other than that covered by his local board he may request that his appeal be submitted to the appeal board having jurisdiction over the area where he resides.

2. Request for determination of essentiality. A physician who receives a Selective Service

A physician who receives a Selective Service induction notice may, if he is essential to his community or hospital and if his essentiality can be documented, request a determination of such essentiality from his local or State Selective Service Advisory Committee. Copies should be sent to the advisory committee where he is located if this is different from the committee governing the area of the board where the physician is registered. Such a request may also be directed to the National Advisory Committee to the Selective Service System, Washington, D. C.

3. Delay in reporting to active duty.

Physicians who have received induction notices and have been commissioned may apply to the Armed Service in which they are commissioned for a delay in reporting to their duty station. Such request must be supported by evidence of essentiality or severe personal hardship.

For those physicians who do not wish to subject themselves to the uncertainties of the draft, the Armed Forces Physicians' Appointment and Residency Consideration Program (Berry Plan) provides for a reserve commission with entry on active duty at one of the following times:

- 1. Immediately upon completion of internship.
 - 2. As late as one year following internship.
- 3. Upon completion of residency training in specialties required by the Armed Forces.

Application may be made for participation in this program early during the intern year. Acceptance into any of the three categories is dependent upon the projected needs of the Armed Services.

Urgent Request: Send in Your Physician's Agreement

As you know, the Illinois State Medical Society is sponsoring a new program for persons over 65 to tie in with the national over-65 program recommended by the American Medical Association. This plan in essence is the answer to the approach to health care typified by the King-Anderson bill, and will help to unite doctors of medicine throughout the country in our fight against socialized medicine.

All physicians in Illinois have been informed of the program through our Journal and by personal letters enclosing a comprehensive brochure listing the provisions of this new Over-65 plan.

The Illinois program — endorsed by the House of Delegates of the Illinois State Medical Society — also needs the support of the individual Illinois physician. That's where YOU come in. This endorsement is in the form of a Physician's Agreement which you have been furnished together with a return postpaid envelope for your convenience. Many of these forms have been received — but some have not.

We don't need to tell you of the importance of this program and the urgency of receiving the active support of every physician in Illinois. If you have not sent in your Physician's Agreement we suggest you do so at once, so that we may get this fine program to work in cooperation with the thousands of physicians throughout our land who are going "all out" to keep our voluntary way of life and of medicine. We urgently ask your immediate cooperation.

"Error is the force that welds men together; truth is communicated to men only by deeds of truth."

- Tolstoi.

Lawyers React to King-Anderson Bill

The following excerpts are from but a few of the many letters being written by members of the legal profession to their Congressmen, opposing the King-Anderson Bill. This active support is deeply appreciated, and is contributing importantly to our fight for defeat of this legislation.

Editor.

Honorable Everett Dirksen Member of the Senate Senate Office Building Washington, D. C.

Dear Senator:

As a professional man, I am against the enactment of the King-Anderson Bill (H.R.4222). The regulation or any semblance thereof, of any profession will eventually lead to the regulation of all occupations with the result there will be little left to fight for to preserve our so-called democratic way of life.

Very truly yours James T. Mullaney Attorney-at-Law

Hon. Everett M. Dirksen Senate Building, Washington, D. C.

In Re: The King-Anderson Bill

Dear Senator Dirksen:

In my opinion the King-Anderson Bill (H.R. 4222) should not be passed. Your opposition to its passage it respectively requested.

It appears to me that not only is a Federal government-controlled program of compulsory

health care for the aged unnecessary in view of the various health insurance policies available to all aged persons, the provisions of the Kerr-Mills Law, and the fact that there are less people over the age of 65 years receiving public assistance today than there were in 1950, but the astronomical costs of such a program would weaken the financial soundess of the United States. Taxpayers now are saddled with a heavy tax burden to support both necessary and unnecessary federal projects and services. An additional payroll tax which would be 40% higher the first year with the likelihood of a payroll tax more than 90% higher in six or seven years will seriously impair the ability of this country to adequately support our vital military needs.

Aside from the extremely high costs and the lack of any real need for such a program there will no doubt be a great deterioration in the quality of medical care to all of our citizens. The experience of England with compulsory medical care under a government program is sufficient to prove this to be true. Fewer capable persons will enter the practice of medicine and those who are in it will be overburdened with work and thus be unable to render patients the personal and effective care patients now receive.

Very truly yours, Edwin W. Merrick Attorney-at-Law

Honorable Paul Findley, Pittsfield, Illinois

Honored Sir:

I am absolutely against the passage of the King-Anderson Bill (4222) and I hope that you

will vote against it as I don't think we need a compulsive Bill like that.

I am past 85 years of age, and if I have to have a Doctor I want to the right to choose the Doctor I want.

So I am hoping that you fight this Bill. I consider it rank folly.

J. Arthur Baird Attorney-at-Law

Everett M. Dirksen Senate Office Building Washington, D. C.

Dear Senator Dirksen:

My wife's Mother was widowed last summer. My mother-in-law is now living on what little she gets from social security and from the income of a very small annuity which she purchased from the meager savings they were able to accumulate. She will be 73 this summer. Her income is barely enough for her living and leaves her with hardly enough to cover her medical expenses. We have supplemented her meager income with occasional contributions to help her keep going. This has not been easy for me, because we have two boys in college.

From the foregoing, one might expect me to be in favor of H.R. 4222. The argument is deceptively persuasive, but I am not buying it. Having had a great deal of experience personally with medical problems, and having heard and read about the experiences of other people in other countries with government medicine, put me down as desiring no part of the same. I am satisfied that government medicine of the type we would get with H.R. 4222 would seriously lower the standard of medical care presently available to everybody and would seriously increase our tax load.

The answer of the proponents of more and bigger government will be that many others are less able to meet this responsibility than I am. Even though I am inclined in many cases to doubt this, the best answer is that, even so, we are still giving the indigent and aged better medical care now than we will be able to do under enforced government medicine.

Sincerely yours, John F. Schmidt Attorney-at-Law Senator Everett M. Dirksen Senate Office Building Washington, D. C.

Dear Senator Dirksen:

I am writing to express my opposition to the King-Anderson Bill H.R. 4222.

I have been in the insurance business for 40 years and feel that this bill would be an encroachment on my means of livelihood.

I have just returned from two weeks in Portadown, Ireland, a suburb of Belfast where they have the benefits of British socialized medicine. In fact I stayed with a family in Portadown, and from talking with them I feel that I wouldn't like it and I don't believe the Dirksen family would like it either, especially in the case of an emergency.

I also talked with a doctor friend in London, and he told me that the young doctors who have some years ahead of them are moving to Australia and Canada to get away from it.

> Yours very truly, Lyman M. Drake, Jr. Attorney-at-Law

Hon. Everett M. Dirksen United States Senator Senate Office Building Washington, D. C.

Dr. Ev:

For some years, I was chairman of the Committee on Independence of the Professions of the Illinois State Bar Association. We made an exhaustive study of Social Security, socialized medicine and the socialization of the professions, and discovered the pattern used by those who desire to convert our Republic into a socialized state.

In our opinion, the King-Anderson Bill approaches this line of legislation, and therefore, I am unalterably opposed to the same. Your professional constituents as well as many others, urgently request that you oppose this socialistic legislation.

Sincerely, Kaywin Kennedy Past President Illinois State Bar Association

Letter to Secretary Ribicoff from W. H. May

The Honorable Abraham Ribicoff Secretary, Department of Health, Education, and Welfare

Dear Secretary Ribicoff:

Our forefathers came to this country because of the unbearable conditions forced on them by governments to establish a new life. Throughout all these years it has been the great mass of our citizens working as volunteers that has made our country great and not government control or intervention.

Here in Illinois, in 1948, rural people decided they wanted the same kind of a health and medical care program that their city counterparts were able to obtain through group coverage. So, through a volunteer organization, the Illinois Health Improvement Association, this has been accomplished. The program encompasses some 70,000 farm families who have the finest group hospital-medical care program that is available at a rate they can pay, which includes people over 65. In fact 25.8% of their membership is over 65! This program is selfsupporting. Therefore, here in Illinois, rural people do not want tax monies to pay for their hospital-medical care programs. They want to be able to solve their own problems on a volunteer basis and determine their own destiny without government subsidy or government intervention.

Let me refer you to the published reports of the hearings and testimony given before the House Ways & Means Committee in July and August of 1961, Volume 4, page 1863. The story of the Illinois Health Improvement Association and suggested alternative is printed per our testimony.

The members of this Association authorized the expenditure of their monies to pay the expenses of myself as the Executive Director and the President, John Rahkemper, to testify before the House Ways and Means Committee. These 70,000 rural families do not believe the King-Anderson approach is sound, nor do they believe it will solve the problem. They have not authorized you or your department to spend tax monies to lobby for this legislation. As tax payers, they believe they have a right to have an accounting from your department of the tax monies expended to promote the King-Anderson Bill (H. R. 4222). By the same token they believe, as a steward of their tax dollars, you have an obligation to provide this information upon request. Therefore, the Board of Directors requests an accounting of tax monies that have been spent in lobbying for the passage of the King-Anderson Bill (H. R. 4222).

> Respectfully yours, W. H. May Executive Director IHIA

Training Foreign Medical Personnel

It is estimated that the minimum number of foreign personnel that will have to be recruited from abroad for the next 10 to 15 years is between 700 and 800, including doctors, engineers, sanitarians and other technicians. Programs have already been started to accelerate the training of Congolese personnel to take over key positions as soon as possible. Thus, 60 Congolese medical assistants have been admitted to five schools of medicine in France, starting in the fourth year of the regular course which leads, three years later, to the degree

of Doctor of Medicine. Assistance was given to the Lovanium University to increase its annual intake of students of medicine from the present number of between 10 and 15 to as many as 40. Fellowships were offered to undergraduates, and 7 of them have started their medical studies in France and in Switzerland (Geneva). Onthe-job training programs for nurses, administrators, and laboratory technicians, will soon be initiated, enabling Congolese personnel to fill key positions in hospitals, laboratories, etc. . . . Reports and Comments. Pub. Health Economics. May 1961.

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Editorials

"Look" Overlooks Need for Scrutiny

Every year several reports appear in magazines and newspapers extolling the merits of questionable remedies. A drug for arthritis is the latest, and the responsibility falls on Look magazine.

The remedy is a liquid formula containing well-known active ingredients which were said to be members of the cortisone family and a male and female sex hormone. The discoverer is an unlicensed Canadian physician — Dr. Robert Liefmann.

According to the Arthritis and Rheumatism Foundation, this remedy contains "potentially dangerous drugs that cannot be given indiscriminately to sufferers." It has not been cleared even for investigative purposes by the Canadian Food and Drug Department. The Foundation reports also that Dr. Liefmann, who has manufactured hairgrowing preparations, skin ointments and vitamins, was brewing adrenals in producing the formula.

Many physicians will blame Look magazine for printing this story. This overlooks the fact that none of us possess a reliable crystal ball. There are just enough exceptions in the history of crackpot ideas to offer an excuse for the publication of articles of this type. Examples include the story that the world was round instead of flat, that contaminated hands were responsible for childbed fever, etc. The journalistic fraternity will justify the story on the grounds that they reported "just what the man

said" even though Dr. Liefmann claims in the Look article that the remedy "could practically wipe out the symptoms of arthritis in one year."

We also realize that "general authoritative scientific opinion" is not always right, but it usually knows the score. The reporter and the editors relied on the source of the material, and hindsight will tell whether the story helped or hindered the battle against arthritis and whether it makes another phony millionaire in the process of destroying the faith millions of arthritics have in honest practitioners.

It would have been better (reputation-wise, not circulation-wise) for Look magazine to use its resources to prove or disprove the claims of Dr. Liefmann. This is easy to do because reliable physicians hestitate and often refuse to risk the life of a patient on a secret remedy. In addition, the use of experimental drugs poses certain legal problems unless given with the full consent of the patient, existing methods of treatment have proven unsatisfactory, and the physician is convinced that the diagnosis is correct. It is unfair also to ask a busy practitioner or research group to drop everything and conduct studies on a drug prepared by persons of questionable scientific integrity.

The editors of Look are close enough to Dr. Liefmann to ask him to allow a group of reputable physicians to observe his results and put them to a critical and scientific appraisal. As an alternative they can try it on several dozen Look employees to determine its safety, whether the hormones produce unwanted side

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effects and whether arthritic conditions melt away.

Imferon Comeback Story

The experience of the Lakeside Laboratories with Imferon is a good example of the uncertainties of the pharmaceutical industry. The FDA forced them to withdraw their injectable iron from the market two years ago, after it was discovered that it induced sarcomas in certain rats and mice. No similar lesions were produced in other animals, and only a questionable sarcoma was reported in man. In addition, more than 12 million injections of Imferon had been given at the time the drug was withdrawn.

The drug is again available because the AMA Council on Drugs argued that the product is no more hazardous than other injectable forms of iron and the transfusions which physicians give as substitutes. In addition, the physician was deprived of a useful drug. Imferon is the same old Imferon. The Lakeside Laboratories took their beating in the true spirit of an ethical pharmaceutical company. The safety of the patient comes first regardless of cost. It costs \$40,000 to withdraw the drug from the market and between \$250,000 and \$300,000 in refunds on returns to customers. The total cost of withdrawal in sales was estimated at \$1,800,000.

Drug Official Raps Labeling, Ad Curbs

President George R. Cain of Abbott Laboratories had the following to say in his report to the shareholders: "Unwise and unneeded regulatory actions remain constant threats." As examples, he mentioned the new labeling regulation on package inserts, which he said would "bring more business to the printing industry, but it is a mystery to us how it can contribute to lower drug costs or how it will get more facts to physicians — who seldom see a package insert, anyway.

"On the one hand, the drug industry has been accused of flooding the physician with too much irformation," he said. "Then we are asked to provide still more, which is largely expensive duplication."

Mr. Cain also attacked the Dingell Bill which demands full disclosure of all contra-indications about drugs in journal advertising. "Time and again, people who know this field have commended medical advertising as the best policed of all advertising, meticulously prepared under medical supervision," he said. "Yet in the face of such opinion, foolish restrictions are proposed for it, ironically in the name of safety.

"Such proposals, unfortunately, add to costs without contributing to consumer protection or to medical progress," he added.



According to the ISMS Constitution . . .

ARTICLE II. PURPOSES OF THE SOCIETY. The purposes of this Society are to promote the science and art of medicine, the protection of public health, to clevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societics, and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

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"SPACE-AGE"

The retiring president of the American Institute of Chemists had this to say about the space race in his farewell address: "Time will be the limiting factor for the long journeys. Our present-day technology would permit us to reach planets of nearby stars, but these trips would require from 30 years upward. Thereafter, mastery of space will depend on our ability to lengthen the effective time of human life. Whoever achieves this control of life extension will also be the first to conquer deep space with all its wealth, all the technology, all the opportunities which this may bring."

In my opinion it will be easier to double or triple the speed of the space machine than to extend life long enough to make trips of this nature. Who would want to spend 30 years of his life traveling to a star and another 30 years returning home? Furthermore, the rewards may not be so wonderful. Perhaps the chemists will discover a super tranquilizer which will make 30 years seem like 24 hours to the space traveler.

ARMY STANDS PAT ON DIET FAT

The Army will not reduce the fat content of the Army diet until it is clearer which fats are more or less desirable nutritionally, in terms of quality and quantity. Standards for caloric and other requirements are set forth in regulations, based on recommendations from the Food and Nutrition Board of the National Research Council. The need to keep the present dietary standards, according to Colonel Ralph C. Singer, MC, is based also on the fact that one half of the Army eats in mess halls, and

this group largely represents young unmarried enlisted personnel who are engaged in vigorous activities requiring diets of high energy foods.

ASPIRIN CITED AS HERPES PREVENTIVE

According to an article in the British Medical Journal, small doses of aspirin prevented the recurrences of herpes simplex in a group of women who were bothered by the virus coincident with their menstrual periods. The aspirin was given 24 hours preceding the day of the expected premenstrual rise in temperature.

ENZYME DEFICIENCY LINKED TO PARKINSONISM

A group from Montreal reported interesting findings relative to Parkinsonism. They noted a decrease in the amount of dopamine and norepinephrine in the brain tissue of patients with this disease. A deficiency of the enzyme dopa-decarboxylase may play a role especially in decreasing dopamine, the immediate precursor of norepinephrine. They noted also that the serum magnesium level in 27 Parkinsonism patients was decreased significantly, compared with that of 20 normal subjects.

NUTRITIONAL QUACK QUELLED

The FDA believes that they have curbed one of the country's leading sources of nutritional quackery. They have sentenced Royal Lee, a dentist and president of the Vitamin Products Company, to a one-year suspended prison term with three years probation. His company, which distributes 115 special dietary products for

treating 500 different diseases and conditions, was fined \$7,000. This is peanuts considering his health food business is estimated at \$3,000,000 a year. Royal Lee is regarded as the leading health faddist in the country and a regular speaker on the subject. Vitamin Products Comany is a Milwaukee concern.

SMOG PLUS SMOKING CANCER CAUSE?

South Africa has relatively clean air, whereas British cities are dirty and smoggy. Dr. Geoffrey Dean of Port Elizabeth, South Africa, found that the death rate among smokers from England is double that of native South Africans who smoked equally as many cigarettes. It is his opinion that polluted air and cigarette smoking interact to produce human lung cancer.

ENGLISH ELIMINATING MENTAL INSTITUTIONS

An English hospital official said that they expect to do away with their large mental institutions during the next ten years. The patients will be moved into general hospitals; an extensive home care program and outpatient and day-hospital facilities are also being planned. They have two objectives in moving the mental patient: 1) to teach the public to regard mental illness in the same way they do any other illness; 2) to bring the standards of provision for mental patients up to those for other patients. The latter offers food for thought.

PHARMACEUTICALS

Gamophen soap (Arwood Division, Ethicon, Inc.) is now available in all drugstores. It contains a full two per cent of hexachlorophene and is available in bar and liquid form. Hexachlorophene is effective against staphylococci and streptococci commonly found in the skin.

Stanazolol is Winthrop's new anabolic hormone. According to a news release from their research institute, the drug has been used in over 600 patients and found to be useful in adding weight among undernourished, listless children; adolescents who are persistently underweight; preoperative and postoperative patients; victims of rheumatoid arthritis; persons

with chronic wasting diseases and old persons with poor appetites. Like other anabolic steroids, the masculinizing effects are minimal; Stanazolol is 30 to 40 times as effective in promoting protein retention as in producing masculine characteristics.

The Knoll Pharmaceutical Company quotes Dr. J. J. Tennent, psychiatrist, as having obtained "excellent results" through the use of Metrazol in the treatment of several hundred senile patients. Best results were achieved in the senile psychotic with cerebral arteriosclerosis. The drug increases respiration and improves cerebral circulation. In the Chicago area, Metrazol often is combined with papaverine.

Edward Dalton Company, division of Mead Johnson and Company, announces Nutrament, a liquid food designed to meet the nutritional needs of older persons, patients recovering from illness, children who are fussy eaters, for civil defense, the pre-game feeding of athletes and the emotionally tense public speaker or entertainer.

Each 12½ ounce can supplies 20 gm. protein, 13.3 gm. fat, 50 gm. carbohydrate, and 400 calories, plus portions of all nutrients known to be needed for human nutrition.

TRACHOMA VACCINATION PROGRAM

The Public Health Service has started a pilot test program of trachoma vaccination among 500 American Indian school children. The first dose was given in April, and the second dose will be given prior to the end of the school year. Reactions are said to be less than those encountered with the usual typhoid vaccines. Up to 40 per cent of American Indian children show evidence of having trachoma, and 50 per cent of those treated each year show reinfection on return to school in the fall.

9 of 10 Physicians Continue Education

Ninety per cent of physicians in private practice in the United States have taken post-graduate or continuing medical education courses. According to *Patterns of Diseases* almost half of these physicians took courses last

year, and a greater percentage intend to take courses this year. Our hat is off to these men and women considering how busy they are.

RESPIRATORY DISEASE RATE RISING

The rising incidence of chronic respiratory disease is becoming a serious problem. Combined mortality from chronic bronchitis, the chronic pneumonias, bronchiectasis and emphysema has doubled since 1959, according to the Metropolitan Life Insurance Company. Emphysema accounted for more than half the increase. Some of the increase can be attributed to the growing proportion of persons of advanced age.

SALK INSTITUTE SEEKS FUNDS

Contributions are still in order for the Salk Institute for Biological Studies now under construction in San Diego, California. The general public was given an opportunity to contribute \$15 million to the fund from June 1 through 15 in a nationwide campaign sponsored by the National Foundation March of Dimes.

NEW AID IN SCIENCE COMMUNICATIONS

A Handbook for Press Arrangements at Scientific Meetings was published recently by the National Association of Science Writers. It is aimed at helping scientists, engineers, and physicians communicate with the public by offering techniques for channeling news to science writers. Copies may be obtained from the National Association of Science Writers, 5 Longview Rd. Port Washington, N.Y. Copies are \$1 each.

WHAT'S NEW

Many attempts have been made to provide patients with tags and cards providing medical information. John M. Lee of Ligonier, Pa., invented a half dollar size aluminum tag for victims of drug allergy. One side is embossed with a brightly colored cross and the words: Warning, Allergy. . . . Known Drug Sensitivity. The offending drugs are listed on the other side of the tag. It did not take Mr. Lee long to discover that 40 per cent of his customers were allergic to penicillin.

The Staplex Company makes a high volume air sampler that is capable of gauging kinds of pollution or contamination. It is used by many companies and governments for air sampling in the field, the plant, at environmental test stations, white rooms, missile sites, etc. It is used for radioactive fallout studies and in industries using newer metals, such as beryllium, nuclear testing, missile work and in the presence of smog.

The Bomgardner Manufacturing Company has a new Swept Wheel "Low-Boy" cot which is only eight inches from the floor. It is low enough to fit into a station wagon which in turn becomes an ambulance. The size of the patient is not mentioned, but the individual is close to the roof of the station wagon. No bumps, please.

A unique concept in the design of emergency bandaging and splinting has been realized by Mine Safety Appliances Company. A clear vinyl plastic bag-like splint is applied to the extremity and held in place under pneumatic pressure. The zipper of the bandage splint is opened, the injured part placed inside and the zipper closed. A valve is opened by counterclockwise rotation, and the bandage is inflated like a balloon by mouth breathing. Inflation continues until bleeding is controlled and the extremity immobilized; the valve is then closed. It is quickly deflated by opening the zipper.

The sheepskin sheet or pad is now being touted by the Leather Industry of America as a preventive for bed sores. It is said to be resillient and airy, distributes pressure evenly, dissipates moisture, and does not wrinkle or chafe. These sheepskins, tanned with the wool left on, can be cleaned with soap and water and dried in the sun. They are spread on the bed, wooly side up.

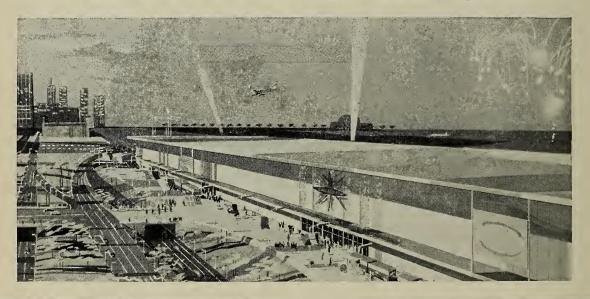
A sensitive antibody test for malaria is being used with good preliminary results by the Public Health Service. The blood test, a modification of the fluorescent antibody technic, is described in the March 30 issue of Science. The procedure will be employed to determine the number of people suffering from asymptomatic malaria—the human reservoirs now undetected.

a medical milestone at America's crossroads

AMA IIIth Annual Meeting

CHICAGO'S MAGNIFICENT McCORMICK PLACE • JUNE 24-28, 1962

This is Chicago's splendid, new exposition center offering every conceivable convenience in the nation's most exciting convention city. More than a convention hall, McCORMICK PLACE is a complex of unobstructed exhibit area, spacious meeting rooms, beautiful theaters, glamorous restaurants and lounges, and colorful promenades adjacent to huge parking lots and enticing lagoons. And in this spectacular setting on the shores of Lake Michigan just a summer stroll from midtown hotels, stores and entertainment districts, air-conditioned McCORMICK PLACE offers you the unsurpassed opportunity to participate in the most comprehensive of all medical meetings, the ultimate in post-graduate education.



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- ★ Eight general programs, never before scheduled, by the combined specialties
- ★ Over 700 exhibits staffed by top researchers and expert technologists
- ★ Surgical innovations and symposia on live color TV and motion picture premieres
- ★ Special daily features representing each medical discipline—and countless other vital programs to serve you in your practice

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street, Chicago 10, Illinois

See JAMA May 19 for complete scientific program...for physician advance registration and hotel reservation forms



Number 32

Normal Laboratory Values of Clinical Importance-Part 2.

FUNCTIONAL TESTS

Basal metabolic rate	minus 10% to plus	10% of magn standard				
	· · · · · · · · · · · · · · · · · · ·	remaining in serum 45 min. after injecting 5 mg. per kg.				
Dioms Midicini	body weight	Tomaining in Scram to min diet injecting o mg. pet kg.				
Cardiac output	3.0 liters/min./squo	re meter body surface area				
Cardiac pressures, mm. Hg	Right atrium, mean	, 0-5				
	Right ventricle:	systolic, 20-30				
		end diastolic, 0-5				
	Pulmonary artery:	systolic, 20-30				
		diastolic, 7-12				
		mean, 12-17				
Cephalin flocculation	No precipitate					
Circulation time						
Calcium gluconate	arm to tongue12.	5 seconds (Average); 10-16 seconds (Range)				
Concentration and dilution	. Sp. gr. of urine afte	er dry day 1.025 or more; after water day 1.003 or less				
Creatine tolerance70% ingested creatine retained in adults						
Galactose toleranceExcretion of not more than 3.0 gm. galactose in the urine in 5 hr. after the						
	ingestion of 40 g					
Gastric test meal, free acid	24-45 un	its (ml. N/10 alkali per 100 ml. gastric fluid)				
	50-100 u					
_	5-150 m					
Glucose toleranceStandard: After ingesting 100 gm. glucose or 1.75 gm. glucose per kg. body						
weight, blood sugar not more than 180 mg. per 100 ml. after ½ hr. and						
return to normal in 2 hr. Sugar not present in all urine specimens						
	Exton: 1/2 hr. blood sugar not more than 75 mg. per 100 ml. higher than					
fasting sugar and 1 hr. blood sugar not more than 50 mg. higher t						
	in the ½ hr. spec	imen				
Hippuric acid Excretion of 3.0-3.5 gm. hippuric acid in urine in 4 hr. after the ingestion						
	of 6.0 gm. sodium					
Or	Excretion of 0.70 g	m. hippuric acid in urine in 1 hr. after the intravenous				
	injection of 1.77	gm. sodium benzoate				
Pancreatic secretion						
	Volume, 20 ml./mir	n.				
	Av. bicarbonate co	ncentration, 25 mEq./L.				
	Av. bicarbonate ra	te of excretion, 0.5 mEq./20 min.				
	Amylase, variable					
Phenolsulfonphthalein	Intramuscular injec	tion: 55-75% in urine in 2 hr.				
		on: 25% or more in urine in 15 min.				
Prothrombin test of liver function .Increase of 15% or more in the prothrombin concentration in the blood in						
	24-28 hr. after th	e injection of synthetic vitamin K				
Pulmonary function tests						

Pulmonary function tests

	Age (in years)			
Total capacity (supine) in cubic centimeters	16-34	35-49	50-69	
(VC = vital capacity)	VC 80 x 100	VC × 100	VC × 100	
Residual volume Total capacity x 100		23.4	30.8	

Vital capacity in cubic centimeters: Males $[27.63 - (0.112 \times age in years)] \times ht. in cm.$ Females $[21.78 - (0.101 \times age in years)] \times ht. in cm.$

Maximum Breathing Capacity, standing, liters/minute

Males [86.5 — (0.522 x age in years)] x body surface area in sq. meters

Females [71.3 — (0.474 x age in years)] x body surface area in sq. meters

FUNCTIONAL TESTS (Continued)

Radioactive iodine (1111) uptake ... 20-50% of administered dose

Radioactive iodine (I¹⁵¹) excretion 30-70% of administered dose in 24 hours following tracer dose, provided renal function is normal

Radioactive iodine, protein-bound, in plasma or serum....less than 0.3% of administered dose per liter of plasma at 72 hours following tracer dose

Renal clearances (corrected to 1.73 sq. meters body surface area)

Inulin clearance (C1) (measure of glomerular filtration rate)

Males 124.1 ± 25.8 cc./min.

Females 119 ± 12.8 cc./min.

Para-aminohippuric acid (C_{PAH}) (measure of effective renal plasma flow)

Males 654 ± 163 cc./min.

Females 594 ± 102 cc./min.

Tubular maximum for PAH

Males 77.2 mg./min. Females 77.2 mg./min.

Secretin Test (1.0 units of secretin as a stimulus) (Dreiling) Response after 80 minutes

 Volume
 HCO₃
 Amylase

 Adults Average
 3.2 ml./kg.
 Average 108 mEq./L.
 14.2 u/kg.

 Infants
 " 58 mEq./L.
 59 u. (Trypsin)*

 Children
 " 62 mEq./L.
 39 u. (Trypsin)*

*Amylase determination unreliable in infants.

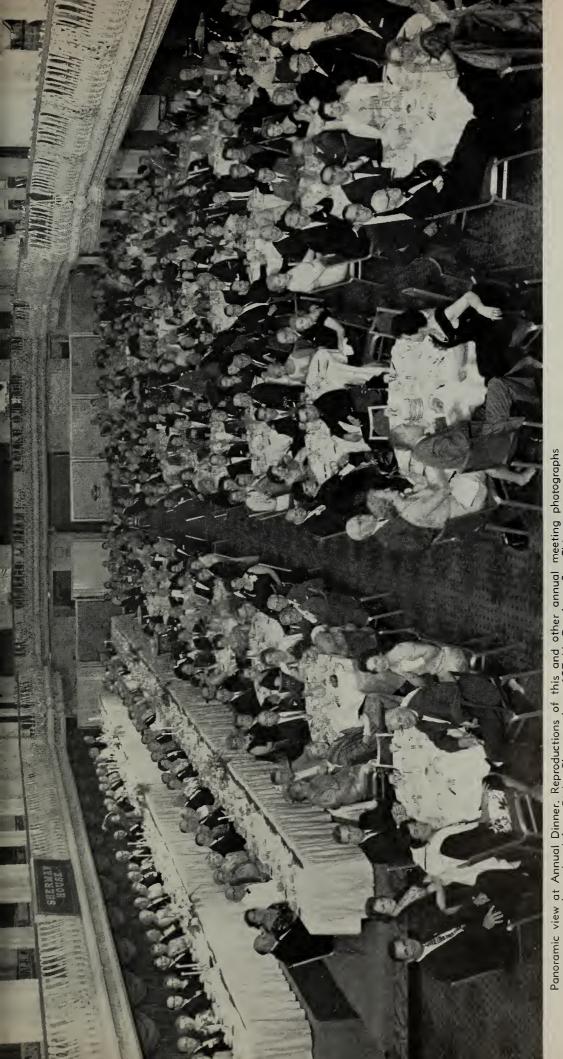
Thymol turbidity test4 units or less

Venous pressure, peripheral vein 60-120 mm. water

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Part III—July 1962 Issue—Bone Marrow, Urine, Stool and Cerebrospinal Fluid

from the linois Medical Journal JUNE, 1962



Panoramic view at Annual Dinner. Reproductions of this and other annual meeting photographs can be ordered from Rialto Photographers, 127 N. Dearborn St., Chicago.

1962 Annual Meeting

George F. Lull, M.D., President, Illinois State Medical Society, 1962-1963



Our New President . . . Stalwart in Troubled Times

Dr. George F. Lull of Chicago accepts the gavel as ISMS president in a troubled period for American medicine. The threat of nationalized medical legislation is imminent. Our own Society, while substantially reorganized, must still endure necessary growing pains.

To anyone but a leader of Dr. Lull's caliber, the role of ISMS president could be viewed as beset with overwhelming problems. Problems, however, frequently have been Dr. Lull's professional heritage — a part he always has accepted willingly and settled with dispatch. He is a medical director of the Cook County Public Aid Department. As ISMS secretary-treasurer in 1959-1960, he served through an arduous period of reorganization. His distinguished career as an Army medical officer spans 33 years, during which time he rose to the rank of major general and in the last two years served as deputy surgeon general of the Army. He is a recipient of the Purple Heart, Distinguished Service Medal, the French Le-

gion of Honor medal and Cuba's Carlos Finlay Order of Merit.

Dr. Lull's experience in medical administration totals 16 years, beginning in January 1946. At that time he joined the AMA as secretary and general manager, and was made assistant to the president in 1958. He retired from the AMA in 1959, at which time he was given acclaim for his "manifold talent — for leadership, extraordinary administrative ability, and capacity for friendship."

In his speech of acceptance as ISMS president, Dr. Lull set aside protocol to come to grips directly with nationalized medical legislation. "America," he said, "is the last bulwark of free medicine in the world . . . Our opponents appeal to the thousands of elderly persons who have been misled into thinking that the King-Anderson Bill is a panacea for medical care . . . It is up to the physicians of this state and the nation to exert enough influence among patients, friends, relatives and associates to offset it.

"Our friends should be educated to the real issues at hand . . . told that not only progress in medicine, but the free enterprise system itself is in danger. We should urge our friends to write and wire congressmen, asking them to oppose this legislation.

"The job seems overwhelming," he concluded, "but it can be done. If we develop a system of communications with our patients and friends, we will achieve victory."

A native Pennsylvanian, Dr. Lull received his M.D. degree from Jefferson Medical College, Philadelphia, in 1909. Subsequently he received the degrees of a Master of Public Health, Harvard; Doctor of Public Health, Pennsylvania; Doctor of Laws, Jefferson Medical College; and Doctor of Science (Hon.) Woman's Medical College of Pennsylvania. He is a fellow of the American College of Physicians and American College of Surgeons, a fellow (Hon.) of the International College of Surgeons and American College of Chest Physicians, and a member of the American Public Health Association and Association of Military Surgeons.

In 1952 Dr. Lull married the former Mildred Louise Beckman of Fremont, Neb., a secretary of the AMA Committee on Medical Service for eight years. She and Dr. Lull reside in Chicago.

Long-time ISMS Leader Appointed President Elect



Harlan English, M.D.

Dr. Harlan English, Danville urologist and pioneer in ISMS organization, has been elected President Elect for 1962.

Dr. English's list of contributions to the Society is long and noteworthy. He has been Councilor for the eighth district since 1946, and also is one of the founding members of the Illinois Public Aid Commission. He helped organize and set up the \$180,000 Student Loan Fund for the education of medical students for rural communities in which there is a shortage of doctors, and is chairman of the Committee on Rural Health and Student Loan Fund.

An active leader in community affairs, Dr. English was chosen Danville's "Citizen of the Year" in 1950. He has been selective service examiner in Vermilion County since the establishment of that office in 1941, and has been a member of the hospital licensing board since its inception nine years ago. He has served as director of the Danville Chamber of Commerce.

Born and raised in east central Illinois, he received his Doctor of Medicine degree from the University of Illinois Medical School in 1933. His many medical affiliations include membership in AMA, American College of Surgeons, American Urological Society, and Council on Medical Education and Hospitals of the AMA. He is an ISMS delegate to AMA.

His wife, Margaret, is president of the Woman's Auxiliary to AMA.

for June, 1962 673



New Officers for 1962-63

QUARTET OF NEW OFFICERS above are (from left) Dr. George C. Turner, Chicago, first vice-president; Dr. Joseph R. Mallory, Mattoon, 2nd vice-president; Dr. George F. Lull, Chicago, president; and Dr. Jacob E. Reisch, Springfield, secretary-treasurer. Below, Dr. Newton Dupuy (left), Quincy, accepts gavel as Chairman of the Board of Trustees from predecessor Dr. E. A. Piszczek, Chicago. Dr. Walter C. Bornemeier (right), Chicago, was re-elected Speaker of the House of Delegates. Vice Speaker (not pictured) is Dr. E. W. Cannady, Chicago.







NEWCOMERS to exclusive 50-Year Club pose for picture after receiving membership certificate and gold pin. Installation services

took place at luncheon meeting Tuesday, May 15. Among the new members installed this year were 50 physicians from CMS.

25th Anniversary of 50-Year Club

The silver anniversary of the 50-Year Club was celebrated this year in conjunction with the 122nd annual meeting of the Society. Club membership totals 520, all Illinois physicians with at least a half century of service in the medical profession. Among newly installed members were Dr. Maude Winnett (right top), Dr. Mabel R. Carlson Johnson (right center), and Dr. Julia C. Aron (not pictured), first women members to be installed in many years. Dr. Morris Fishbein (bottom right), the president of CMS and world-renowned medical figure, receives membership certificate. Oldest living member is Dr. R. E. Wyant, age 95, pictured at bottom left with his daughter. Dr. Wyant came all the way from Palo Alto, California to attend meeting.









Celebrity Speakers



DR. EDWARD R. ANNIS of Florida, America's outstanding spokesman against government interference in medicine, addresses Phi Chi Luncheon. ISMS dignitaries flanking Dr. Annis are (from left) Dr. Percy Hopkins, past president; Dr. Jacob E. Reisch, secre-

tary-treasurer; Dr. H. Close Hesseltine, past president; and Dr. Fred Stocker. Dr. Annis also was guest speaker at Annual Dinner, talking on "Patients and Politics." Five days later he gave nationally televised rebuttal in answer to Kennedy's Medicare rally.



TV's "MAN ON THE GO" Alex Drier was keynote speaker at the combined PR and medical economics luncheon. An American Broadcasting Company television commentator and veteran newsman whose assignments have included the Kremlin and the North African invasion, Mr. Drier gave his interpretation of some of the problems facing medicine today and what he believes could be done to solve them.







CAMP MEMORIAL LECTURE was given by Dr. B. Marden Black, (top) Head of Surgery Section at Mayo Clinic. Dr. William R. Best, (bottom left) Assistant Professor of Medicine, University of Illinois, gave the Oration in Medicine. This year's Oration in Surgery was given by Dr. Stuart Roberts (bottom right), Instructor in Surgery, University of Illinois Research Hospital.

ENDOCRINE AND PHARMACEUTICAL PRODUCTS OF QUALITY

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An important announcement to physicians who prescribe corticosteroids

Organon's new technical process now makes one of the newer, most highly potent and well tolerated corticosteroids available at greatly reduced cost to your patients with allergic, arthritic or other inflammatory conditions.

This new product is being marketed under the trade name of HEXADROL, brand of dexamethasone 'Organon'. HEXADROL is now being offered to your pharmacist at a price which should make it available to your patients at a cost well within the price range of older generically prescribed corticosteroids. It is supplied as 0.75 mg. white scored tablets, in bottles of 100.

If you have been prescribing the older corticosteroids—such as prednisone, prednisolone, hydrocortisone or cortisone, and have hesitated to prescribe the newer corticosteroids because of economic consideration for your patients, you can now secure all of the clinical advantages of dexamethasone at approximately the same prescription expense. Mg. for mg., HEXADROL is approximately 6 times more potent than triamcinolone or methylprednisolone...8 times more potent than prednisone or prednisolone...28 times more potent than hydrocortisone...and 35 times more potent than cortisone.

If you are now prescribing the newer corticosteroids—such as triamcinolone, betamethasone, paramethasone or another brand of dexamethasone, because of reduced risk of sodium and fluid retention, potassium depletion, or disturbance of glucose metabolism—you can obtain all of these benefits with HEXADROL, at marked savings—yet with complete assurance of unsurpassed quality and therapeutic effect.

For complete information concerning HEXADROL—including indications, dosage, precautions and side effects—or if you would like a trial supply, ask your Organon Representative, or write to: Director, Professional Services, Organon Inc., West Orange, N. J.

'Organon'—your professional assurance of quality Hexadrol®—your patient's assurance of economy!

Meetings and Scientific Sessions . . .









HOUSE OF DELEGATES in session Sunday evening, May 13, (top). Lt. Col. William F. Peterson (above left), Chief of Ob-Gyn at Andrews Air Force Base, addresses Obstetrics and Gynecology Section on "Spartocin Sulphate in Inductions and/or Stimulation of Labor." Above center, Dr. Edwin S. Hamilton receives gift on termination of his office as ISMS president from Dr. E. A. Piszczek. At Section on Preventive Medicine and Public

Health, Dr. Herbert Ratner (above right), Section chairman, addresses panel discussion group. U. S. District Court Judge Julius Miner (below left) addresses Impartial Medical Testimony breakfast meeting. Five other judges representing U. S. District and State Superior and Circuit courts attended the breakfast. Line-up at registration desk (bottom right). Of this year's 2,769 registrants, 1,421 were physicians.





... With Time Out to View Exhibits





A total of 106 exhibits, 35 scientific and 71 technical, filled the mezzanine area of Sherman House with features of interest to ISMS members. Gold Medal for educational scientific exhibit was awarded for entry "The Pathology of Congenital Heart Disease" (top left). Original exhibit Gold Medal award was won for "Subtotal Resection in Selected Cases of Solitary Unicameral Bone Cyst" (above right). As always, technical exhibits proved to be one of the high points of interest at the meeting (below).













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because of its efficacy, relative freedom from side effects...and its excellent flavor which makes administration a pleasure instead of a project

equally effective for grownups

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*Literally, of course, anxiety is not "communicable" os the word is commonly used, but you probably see mony potients whose emotional disturbances are transmitted to ond reflected in the people who are closest to them.

VITERRA® Copsules - Tostitobs®
Therapeutic copsules for vitamin-mineral supplementation



NEWS and ANNOUNCEMENTS



Cook County

M.D.'s in the News

Dr. Edwin S. Hamilton, Kankakee, immediate past president of the Illinois State Medical Society, participated as a judge in the Illinois High School Essay Contest conducted by the Illniois Society for Medical Research. The ISMS is one of the five societies sponsoring the statewide contest, and the five respective presidents acted as judges. . . . The two physician members of the Chicago Committee for Project HOPE are Dr. Lowell T. Coggeshall, vice president, Medical and Biological Program, the University of Chicago, and Dr. Eric Oldberg of Chicago. . . . Dr. Samuel Liebman of Forest Hospital, Des Plaines, is the new president elect of the National Association of Private Psychiatric Hospitals. He is a professor of psychiatry at the University of Illinois.

Honors Bestowed

Dr. H. Stanley Bennett, dean of the division of biological sciences at the University of Chicago, received an honorary doctor of humanities degree from Monmouth College at commencement ceremonies June 4.

The Gold Medal for Achievement of the American Academy of Dermatology, Inc., has been won by *Dr. Stephen Rothman*, professor emeritus of medicine of the University of Chicago. Dr. Rothman is internationally known for his research on pigmentation, secretion of oil by the skin, growth of hair and skin cancer.

Dr. Gerald A. Mendel, an instructor in the department of medicine at the University of Chicago, has been awarded the Joseph A.

Capps Prize for Medical Research given by the Institute of Medicine of Chicago. The \$500 prize is given for the most meritorious investigation in medicine or its specialties.

Drs. Benjamin Boshes and John S. Gray have been named to endowed chairs at Northwestern University Medical School. Dr. Boshes became the Charles H. Mix Professor of Neurology and Psychiatry, and Dr. Gray was named the Nathan S. Davis Professor of Physiology.

Two Chicago physicians were recently honored for outstanding service to Presbyterian-St. Luke's Hospital. They are *Foster L. McMillan* and *George W. Stuppy*, who jointly wrote the bylaws under which the 367-member staff now operates.

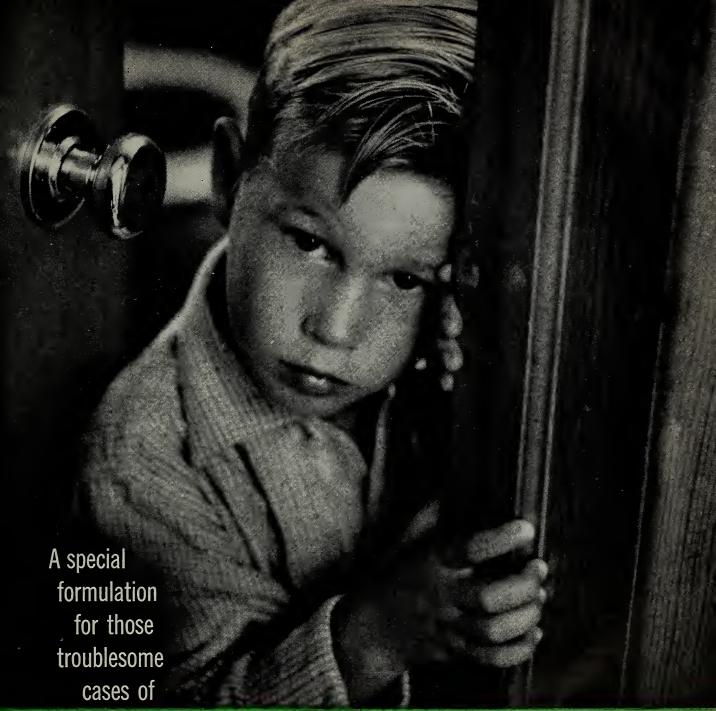
General

U.S. National Health Survey Exams in Jackson-Franklin-Williamson Counties

The Public Health Service's Health Examination Survey will visit the State of Illinois for the third time when a sample of the population of Jackson, Franklin, and Williamson counties is examined during a three week period beginning July 18.

In the fall of 1960 and again in the summer of 1961, about 150 persons from the northern part of the state were examined. Now, a similar number of adult residents will be examined in this three-county area.

The persons to be examined are chosen at random from the whole population of the three counties — irrespective of their social, economic or health characteristics. The examination will be performed in the Health Survey's mobile examination center, which will be brought to Carbondale and set up in a convenient location.



acute nonspecific diarrhea

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Provides greater assurance of more comprehensive relief in acute self-limiting diarrheas through the time-tested effectiveness of two outstanding antidiarrheals - DONNAGEL and a paregoric equivalent. Tastes good, too!

Each 30 cc. (1 fl. oz.) of Donnagel-PG

24.0 mg. 6.0 Gm. 142.8 mg.

Pectin
Natural belladonna alkaloids
hyoscyamine sulfate
hyoscine hydrobromide
Phenobarbital (¼ gr.) SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz. Also available:

DONNAGEL® with NEOMYCIN _ for control of bacterial diarrheas.

DONNAGEL® - the basic formula when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC. Robins RICHMOND 20, VIRGINIA



The purpose of the examinations is to collect statistical information on certain chronic conditions, particularly cardiovascular diseases and arthritis, and on physical and physiologic measurements. It consists of a medical history, a physical examination for certain conditions, a dental exam, screening tests for visual acuity and hearing, a 12-lead electrocardiogram, blood pressure determinations, six foot 14x17 chest x-ray, x-rays of hands and feet, modified glucose tolerance test, microhematocrit determination, serologic test for syphilis, serum cholesterol level, serum bentonite flocculation test, urine sugar (plus albumin for males), height and weight, and a series of body measurements important in the design of motor vehicles, aircraft and farm and industrial machinery.

Although findings are not disclosed to examinees directly, each one is asked if he wishes the findings supplied to his own dentist and physician. The health exam is not intended as a screening procedure; referral for diagnosis is not made. The fact that it is not complete and not a substitute for a visit to one's own physician and dentist is stressed.

The examining physicians will be fellows or senior residents in internal medicine working temporarily with the Public Health Service. The other team members are nurses, a dentist, x-ray technicians and history interviewer-receptionists regularly on the PHS staff.

The Health Examination Survey is nation-wide and is a major project of the U.S. National Health Survey authorized by Congress in 1956. It constitutes the first attempt in any country to perform examinations on a representative sample of the national population.

The Jackson-Franklin-Williamson counties "stand" will be the 36th in the national sample. The data gathered will not produce separate figures for localities or states. When all the "stands" are completed, the results will yield estimates for the United States as a whole.

Another part of the National Health Survey program is a Health Interview Survey begun in July 1957 which has already produced reports on topics which can be investigated appropriately by this technique. Among the topics published so far are physician visits, dental care, disability, persons injured, acute illnesses, hospitalization, impairments and broad groupings of chronic conditions.

AMA Meeting Committee Needs Helpers

Illinois plays host to the American Medical Association's 111th Annual Meeting June 24-28. A special Committee on International visitors under the Local Committee on Arrangements has been formed to provide hospitality to physicians and their families from abroad who attend the meeting. Dr. Fred A. Tworoger is chairman. They need your help in providing entertainment and hospitality.

Physicians willing to volunteer their services should contact Dr. Tworoger, Chicago Medical Society. Other committee members are: Drs. George B. Callahan, Morris Fishbein, Percy E. Hopkins, George Lull, Eugene F. Lutterbeck, Francis A. Oslay, H. Kenneth Scatliff, and Frank J. Walsh; and Mrs. Richard E. Westland, president of the Illinois Chapter of the Woman's Auxiliary to the AMA.

Appointments and a Retirement in Springfield

Drs. Caesar Portes, Chicago, and David F. Rendleman, Carbondale, have been named as members of the Advisory Board to the Division of Cancer Control in the Illinois Department of Public Health.

Another appointee in the department, this time to its Board of Public Health Advisors, is Dr. John A. D. Cooper, associate dean of the Northwestern University Medical School. His term expires July 1, 1963.

Willard L. Couch, deputy director of the Illinois Department of Mental Health, will retire on June 30, completing 33 years of service with this department.

New Ob-Gyn Certifications

Eighteen Illinois physicians received certification from the American Board of Obstetrics and Gynecology this April. Their names follow:

Kenneth W. Anderson, Robert C. Burchell, Hugh G. Grimes, Sheldon A. Nemerovski, Warren H. Staley, and Bernard B. Zelinger, all of Chicago.

Bennett I. Berman, McHenry; Thomas C. Gallanis, Evanston; Daniel C. Good, Great Lakes; Edward J. Jacobs, Arlington Heights; George R. Johnson, Oak Park; William C. Katel,



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Literature on request

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-ANNOUNCEMENTS -

Geriatrics Society Will Meet in Chicago

An invitation is extended to all physicians to attend the annual meeting of the American Geriatrics Society June 18-20 in Chicago's Palmer House. A special session for laymen, "Partnership for Progress in Geriatrics," opens the meeting and will present the discussions "The Importance of Understanding the Problems of Aging," "Preparing the Mind for Maturity," and "The Layman's Role in a Geriatrics Program."

The major motifs for physicians will be geriatric medicine, surgery, cancer control, and socioeconomics.

There is no registration charge. Further information may be obtained from Mr. Henry

Blanchard, executive director of the Society, 10 Columbus Circle, New York 19.

Jottings

The American Medical Women's Association is inviting all women physicians attending the annual meeting of the AMA in Chicago to be their guests at a brunch on Sunday, June 24, at 11:00 a.m. in the Essex Inn.

"Medical Woman Power — Can It Be Used More Efficiently" will be discussed by a panel with audience participation.

The Association requests that it be notified at 1790 Broadway, New York 19 of acceptance.

PG Courses

June 23-24 are the dates of a postgraduate course on Rheumatic Diseases sponsored by the Chicago Rheumatism Society and the American Rheumatism Association to be held at the Edgewater Beach Hotel. The subjects of the two panel discussions are "Rheumatoid Factor" and "Surgery in Arthritis."

Nervous Geriatrics



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Other talks will be on "Pathogenesis of Gout," "Connective Tissue Metabolism," "Autoimmune Mechanism," "Medical Diseases Presenting As Arthritis," "Nephritis in Lupus Erythematosus," "Arthritis in Children," "Steroid Therapy," and "Physical Medicine in Arthritis."

The registration fee is \$20; the course will be acceptable for ten hours of category two credit by the American Academy of General Practice.

"Medical and Surgical Aspects of the Retina" is the subject of this year's postgraduate course in ophthalmology presented by the University of Colorado School of Medicine at the Stanley Hotel, Estes Park, Col., July 9-12.

Topics for presentation and discussion will be "Differential Diagnosis of Retinal Detachment," "Present Status of Diabetic Retinopathy," "Effects of Uveitis on the Retina," "Differential Diagnosis of Macular Lesions," and "Macular Lesions."

Other subjects are "Consideration of Macular Degeneration," "Therapy of Vascular Diseases of the Fundus," "Inflammatory Retinal Detachments," "Scleral Buckling Procedures," "Examples of Scleral Resection," and "Photocoagulation."

Planned entertainment includes a chuck wagon dinner, a visit to the Central City opera and the society's annual banquet.

The tuition fee is \$60. Write the office of postgraduate medical education at the University, 4200 E. Ninth Ave., Denver 20, for details and registration forms.

Annual Cancer Conference in Denver

This year's Rocky Mountain Cancer Conference will run July 13 and 14 at Denver's Brown Palace West Hotel and will feature panel discussions on "Neoplasms Complicating Pregnancy" and "Carcinoma of the Colon."

Morning sessions on both days will be devoted to panel discussions followed by round table luncheons; individual papers will be delivered during the afternoon sessions. The conference is jointly sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society.

Further information may be obtained by writing the Conference at 1809 E. 18th Ave., Denver 18.

Leukemic Patients Sought for Study

The cooperation of physicians is requested in a study of chronic myelogenous leukemia being conducted by the Chemotherapy Service of the National Cancer Institute at the Clinical Center, National Institute of Health, Bethesda, Md.

Patients with this leukemia, including some treatment-refractory patients with high white blood cell counts, are needed for studies of newer chemotherapeutic agents. They also are sought as a source of white cells and platelets for *in vitro* and *in vivo* study. Those accepted will be hospitalized 8 to 12 weeks.

Physicians wishing to have their patients considered may write Dr. Paul P. Carbone, Chemotherapy Service, Medicine Branch, National Cancer Institute, Bethesda 14.

Clinics for Crippled Children

- July 5 Peoria (Cerebral Palsy), Roosevelt School
- July 6 Chicago Heights (Cardiac), St. James Hospital
- July 10 East St. Louis, Christian Welfare Hospital
- July 10 Peoria (General), Children's Hospital
- July 11 Champaign-Urbana, McKinley Hospital
- July 11 Hinsdale, Hinsdale Sanitarium
- July 12 Cairo, Public Health Building
- July 12 Flora, Clay County Hospital
- July 12 Springfield (General), St. John's Hospital
- July 12 Sterling, Community General Hospital
- July 17 Alton (General), Alton Memorial Hospital
- July 17 Danville, Lake View Hospital
- July 17 Quincy, St. Mary's Hospital
- July 18 Joliet, Silver Cross Hospital
- July 19 Elmhurst (Cardiac), Memorial Hospital of DuPage County
- July 19 Decatur, Decatur and Macon County Hospital
- July 19 Rockford, St. Anthony's Hospital
- July 20 Chicago Heights (Cardiac), St. James Hospital
- July 24 Peoria (General), Children's Hospital
- July 25 Elgin, Sherman Hospital



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Vitamin B-2	3 mg.	3 mg.	0.5 mg.
Vitamin B-6	1 mg.	1 mg.	0.15 mg.
Vitamin C	100 mg.	100 mg.	15 mg.
Vitamin E	1 I.U.	1 I.U.	
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July 25 Centralia, St. Mary's Hospital

July 25 Springfield (Cerebral Palsy — p.m.), Memorial Hospital

July 26 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital

July 26 Mt. Vernon, Masonic Temple

Deaths

Clifford Doyle, Sr., Chicago, a graduate of the Chicago Medical School in 1923, died April 18, aged 65. He was a staff member at Provident Hospital, where he had been chairman of the department of general practice from 1954 until the past year. He was a former president of the Cook County Physicians Association and of the Prairie State Medical Society. In World War II he was on the city ration board; he also belonged to the National Medical Association.

Delmer R. Duey, retired, Belleville, a graduate of Washington University School of Medi-

cine in 1908, died April 9, aged 79. He had practiced in Belleville from 1910 until his retirement in 1946.

Thomas S. Egan, Peoria, a graduate of the University of Illinois College of Medicine in 1905, died December 6, aged 82. He belonged to the Chicago College of Physicians and Surgeons and was on the courtesy staff at St. Francis Hospital.

Benjamin M. Gasul*, Chicago, a graduate of Rush Medical College in 1925, died April 29, aged 63. A certified pediatrician, he was a staff member of Cook County Children's, Mount Sinai and Presbyterian-St. Luke's hospitals and Research Hospital of Illinois. At one time he was in charge of the cardiac division at Mount Sinai Hospital and for many years was chief of the pediatric cardiac department of Cook County Hospital.

He also was founder and director of the pediatric cardio-physiology department of the Hektoen Institute for Medical Research and Cook County Children's Hospital. He was pro-



fessor of pediatrics at the University of Illinois Medical School and in 1927, 1928 and 1933 was a resident pediatrician at Professor-Pirquet Children's Clinic of the University of Vienna, Austria. A fellow of the American College of Physicians, he also belonged to the American Academy of Pediatrics and the American College of Chest Physicians.

Albert E. Goebel, Montrose, a graduate of St. Louis University School of Medicine in 1916, died April 19, aged 77. From 1942 to 1959 he was president of the Effingham County Tuberculosis Sanitorium Board. He had practiced in Montrose 43 years and was a member of the town school board 15 years.

Perry F. Jones*, retired, St. Petersburg, Fla., a graduate of the Chicago College of Medicine and Surgery in 1907, died April 17, aged 88. He maintained a practice in Peoria many years prior to retiring in 1949 and moving to Florida. He belonged to the Illinois State Medical Society's 50-Year Club.

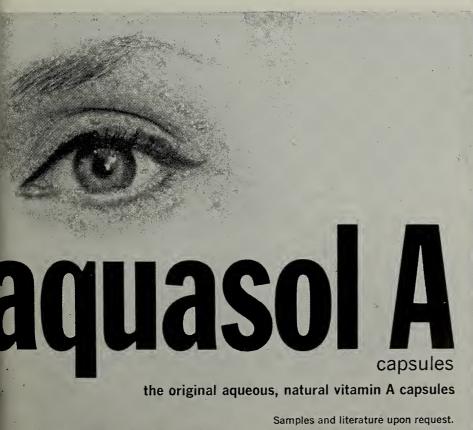
Sedat A. Kayar*, Highland, a graduate of the University of Istanbul Medical Faculty, Turkey, in 1945, died March 1, aged 41. He had practiced in Highland for eight years.

Leon Newman, Chicago, a graduate of Bennett Medical College in 1915, died March 17, aged 70. He was a Chicago physician 45 years.

George L. Perusse, Jr.*, Chicago, a graduate of Rush Medical College in 1930, died April 10, aged 58. He was on the staff of Grant Hospital.

Charles L. Patton*, retired, Springfield, a graduate of the University of Michigan Medical School in 1902, died April 18, aged 82. He retired in 1942 after 37 years of practice in Springfield. During World War I he was president of the District Exemption Board and later served as a major in the U.S. Army Medical Reserve Corps in France.

In 1937 he received certification in surgery; he was a charter member of the American Board of Surgery, a fellow of the American



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College of Surgeons and belonged to the Western Surgical Association and the American Society for the Study of Trauma. He also had emeritus membership in the ISMS.

Ferdinand H. Pirnat*, retired, Chicago, a graduate of the University of Michigan Medical School in 1907, died May 6, aged 87. He retired in 1954 after 57 years of Chicago practice which included memberships on the staffs of St. Mary of Nazareth, Grant and Norwegian-American hospitals. He had emeritus status in the Illinois State Medical Society.

Thomas V. Plews*, Petersburg, a graduate of Queens University Faculty of Medicine, Kingston, Ontario, in 1922, died April 6, aged 74. He had a medical practice in Petersburg since 1926 and was a past president of the town Rotary Club and an honorary member at the time of his death, also serving on the town board of education from 1938 to 1946.

He was a past president of the Menard County Tuberculosis Association and at the time of his death had been secretary for a number of years. He also was several times president of the Menard County Medical Society and since 1949 was the county coroner and county health officer. In Springfield he was a staff member of St. Johns and Memorial hospitals and in Havana the Mason District Hospital. In World War I he joined the British Army Medical Corps, later receiving the French Croix de Guerre.

George J. Powers, Sr.*, Streator, a graduate of the University of Illinois College of Medicine in 1905, died April 3, aged 79. He belonged to the 50-Year Club of the Illinois State Medical Society and also was an emeritus member.

Leslie O. Sale*, retired, Fisher, a graduate of Northwestern University Medical School in 1896, died April 26, aged 89. He began practice in Fisher 65 years ago and was a member of the Masonic Lodge, Knights Templar, Shrine and Lions Club there, in addition to emeritus membership in the ISMS.

Siegfried G. Schmidt*, Chicago, a graduate of Julius-Maximilians-Universitat Medizinische Fakultat, Wurzburg, Bavaria in 1920, died May 6, aged 68. He belonged to the American Academy of General Practitioners and the German Medical Society and was vice president of the staff of Alexian Brothers Hospital and a member of the Columbus and Cuneo hospital staffs. He came to the United States from Germany in 1935.

Phillip L. Shtair*, Normal, a graduate of Indiana University School of Medicine in 1949, died January 8, aged 39. Before 1957 he had practiced in Marion, Ind., and since coming to Normal that year had been an associate in the Fruin Clinic. He was a member of the Illinois Heart Association.

Solomon Singer*, Chicago, a graduate of the University of Illinois College of Medicine in 1935, died April 24, aged 55. During World War II he was a major in the U.S. Army Medical Corps.

Clarence F. Van Atta*, Ottawa, a graduate of the State University of Iowa College of Homeopathic Medicine in 1912, died April 7, aged 75. He did graduate work at the New York Ophthalmic Hospital and had emeritus status in the Illinois State Medical Society.

*Indicates member of Illinois State Medical Society.



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General Surgery, One Week, May 7; Two Weeks,
April 2

Gynecology, Office & Operative, Two Weeks, April 9 Vaginal Approach to Pelvic Surgery, One Week, March

Obstetrics, General & Surgical, Two Weeks, March 12 Pain Relief in Childbirth, 3 Days, March 7 Proctoscopy & Sigmoidoscopy, One Week, March 26 Treatment of Varicose Veins, One Week, March 26 Basic Internal Medicine, Two Weeks, March 26 General Practice Review, One Week, May 21 Basic Electrocardiography, One Week, March 19 Gallbladder Surgery 3 Days, March 12 Surgery of Hernia, 3 Days, March 15 Urology, Two Weeks, April 2 Surgery of the Hand, One Week, April 16

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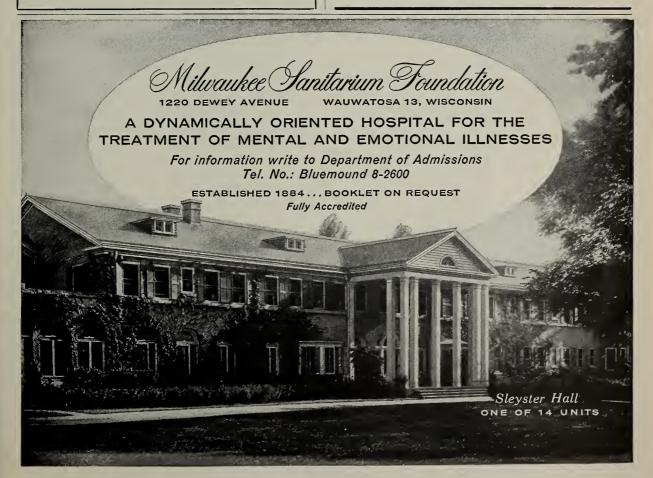
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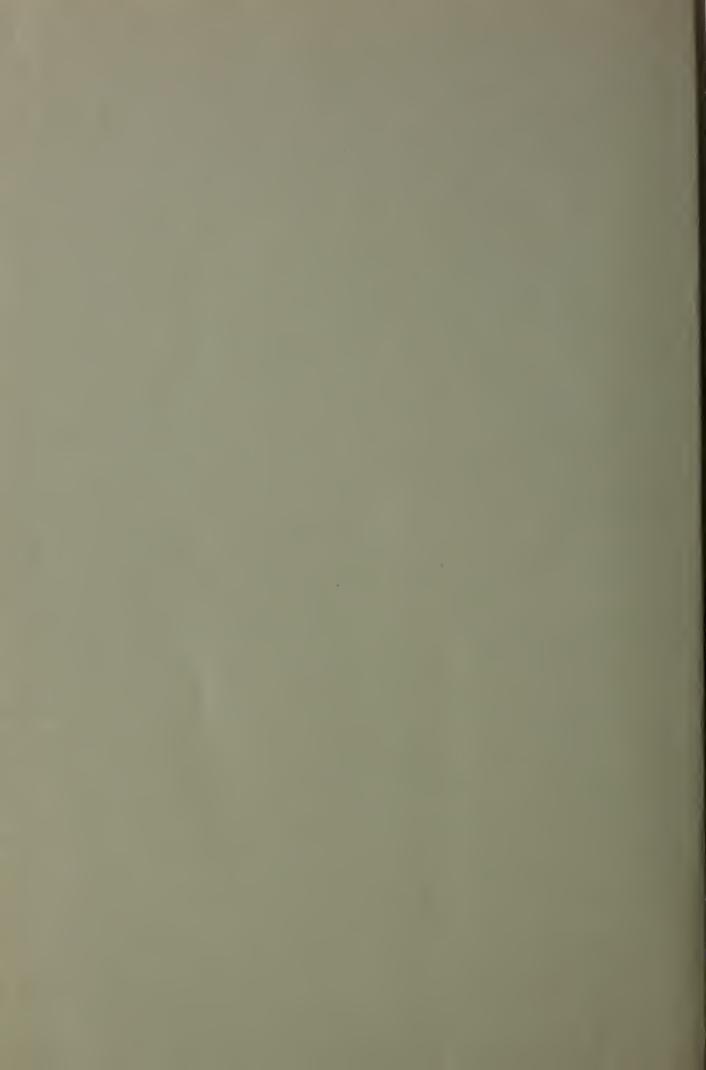
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